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ABSTRACT

This report summarizes state-by-state data on the number of children and adults in foster homes administered by child welfare or social service agencies. As of December 1985, there were approximately 261,000 children in out-of-home foster care, including 54,000 handicapped children, of whom 14,000 were mentally retarded. Telephone interviews and questionnaire surveys were used to gather the data from various state agencies and selected county social service agencies. In the area of children's foster care, findings are presented on the number of children in foster care, foster children with handicaps, longitudinal trends in foster care, state-by-state changes in foster care placements, statewide management information systems for children, and foster care program operation. On the topic of adult foster care, data are presented on the number of adults in foster care and the management of adult foster care programs. The report also describes specialized foster care and offers an assessment of the differential availability of foster care statistics at the state and county levels. Recommendations are offered to improve the quality of foster care data available. An appendix contains tables detailing, for each state, the number of children in foster care by type of placement and by type of disability (mental retardation; emotional disturbances; specific learning disability; hearing, visual, or speech impairments; and physical or health handicaps). (JDD)

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Foster Care for Children and Adults with Handicaps: Child Welfare and Adult Social Services

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Abstract

This report summarizes state-by-state data on the number of children and adults in foster homes administered by child welfare or social service agencies. As of December, 1985, there were approximately 261,000 children in out-of-home foster care, including 54,000 handicapped children, of whom 14,000 were mentally retarded. The total number of children in foster care on any one day has decreased only slightly since 1980, whereas the number of children reported to be mentally retarded decreased by approximately 7,500 (35%) to 5.3% of all foster children. Specialized foster homes administered by state mental retardation agencies serve approximately 6,400 additional mentally retarded children and 10,700 mentally retarded adults.

Adult social services foster care programs and data collection efforts regarding children and adults in foster care are also discussed. Many states gather and can report detailed data on both handicapped and nonhandicapped foster children. In other states, only counties can provide data on handicapped children. Data collection efforts would benefit form standardization of terminology used by states.

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Foster Care for Children and Adults with Handicaps:
Child Welfare and Adult Social Services

I. Introduction

Background

When natural families, for various reasons, cannot or will not provide adequate care for dependent family members, whether for reasons of dysfunction of the family unit, disability or delinquency of the family member, or other reasons, public agencies often assume the role of ensuring that the dependent individual will receive appropriate food, shelter, clothing, and nurturance. A number of specialized institutions have evolved over the decades to implement this public commitment. These include a variety of residential and nursing institutions, group homes, halfway houses and other facilities for persons with dependencies due to age or disability. A primary and extremely important setting for fulfilling the public commitment to dependent persons living outside their natural homes is foster care.

The most common use of foster care is as a setting in which children's basic needs for food, shelter, clothing, and nurturance can be met at times when their natural families are unable to do so adequately. Public Law 96-272, the Adoption Assistance and Child Welfare Act of 1980, partly in response to a growing caution about the use of long term or repeated out-of-home foster care placements, established the concept of permanency planning for children as a national policy. A primary purpose of this Act was to promote a reduction in the number of children in foster care, reduce the duration of care, and improve preventative and family-based support services and case management to promote more stability in the lives of foster children. While it is difficult to obtain statistics that demonstrate the effects of the permanency planning effort, available statistics (discussed later in this report) suggest that although placement duration may have decreased somewhat, the number of children and youth in foster care at any one time did not change appreciably between 1980 and 1985.

Foster care is also becoming increasingly important as a long-term placement for persons with disabilities. Although the foster care model of residential services to persons with disabilities gained considerable attention in the first third of this century, interest waned from the early 1930s until the late 1960s. Since then, as greater stress has been placed on community integration and normalized lifestyles for persons with mental, physical and/or sensory impairments, there has been increasing attention on maintaining persons with disabilities in their natural homes or in the most home-like long-term care placement possible. Obviously in pursuit of this goal, foster care arrangements are particularly attractive.

To examine the role and potential of foster care in responding to the long-term care needs of persons with disabilities, it is important to observe the administrative structure through which long-term care services are provided. The present study emphasizes services to persons with mental retardation/developmental disabilities, but analogies exist in services to other "disability groups" with long-term care needs. For persons with mental retardation/developmental disabilities, the largest long-term care service system is operated, licensed, administered and funded by state departments or divisions of mental health or mental retardation and is primarily comprised of state institutions, large private institutions, relatively small group homes, and specialized foster homes. The state mental retardation residential service system serves approximately 250,000 persons, about 25% of whom are less than 22 years old. Foster homes specially licensed by state mental retardation agencies (referred to in this report as "specialized foster homes") served 6,400 children and youth (0-21 years) and 10,700 adults in 1982, an increase of almost 20% from 5 years earlier (while the total residential service system remained about the same size).

The second largest system of long-term care for persons with developmental disabilities is made up of nursing homes and personal care homes, generally operated under

the supervision of state departments of health. The most recent available data on placements in such facilities are provided by the 1977 National Nursing Home Survey (NCHS, 1979). Its estimates indicated that among the 1,303,000 people in nursing homes in 1977 there were about 44,000 persons with a primary diagnosis of mental retardation or a diagnosis of epilepsy with mental retardation as additional handicap.

The third system of long-term care, and the focus of the present study, is operated by state social service agencies. This substitute care is comprised of foster homes, group homes, and other types of residential facilities. Typically, this system is operated through county departments of social services, although some states administer foster care through regional offices. In this report, residential services provided by child welfare or adult social service systems will be referred to as *generic foster care* to differentiate them from the *specialized foster care* programs administered by state mental retardation, mental health, or other agencies focused on specific disability groups. According to an Office for Civil Rights Study (OCR, 1981) which will be discussed later in this report, about 267,000 children and youth, including 64,000 children and youth with handicaps, 21,000 of whom were mentally retarded, were in generic substitute care programs in 1980 (includes age birth to 17 years; excludes independent living).

Foster care is generally considered to be a child welfare service, but in some states and counties adult foster care programs have also been established. Nearly two thirds of residents in specialized foster care programs administered by state mental retardation agencies are adults. Many states have also established foster home programs for adults with mental illness and/or those who are elderly and/or disabled, although data on the number of persons mentally ill and elderly participating in foster care programs do not appear to be available. For the most part, both generic and specialized foster adult care programs for persons with disabilities rely on funding assistance available to participants through the Social Security Act (Supplemental Security Income, Social Security Disability

Insurance, Medical Assistance), often supplemented by state programs. Under the Medicaid Home and Community-Based Services waiver, Title XIX funds are also being used to support the care, supervision and training provided to adults living in foster homes. Certainly cost is of major importance as one looks to the future of foster care programs for persons with disabilities. In a recent (1986) sample of specialized foster care homes and small group homes (6 and fewer residents) for people with developmental disabilities, we found that foster care homes had an average daily cost of $23.03 versus $48.60 for small, licensed (but not ICF-MR certified) group homes.

Numerous factors suggest greater utilization of foster care arrangements to meet the long-term care needs of people with disabilities in the future. Among the advantages of foster care are the more normal patterns of daily living they provide residents, their integration within the community and, of course, their low cost. Unfortunately, while data are increasingly available on the nature, size, and quality of specialized foster care programs, even the most basic statistics on generic foster care services are difficult to obtain. Among the most obvious reasons for this lack of comprehensive data is that generic foster care programs are operated by approximately 2,500 separate jurisdictions.

Purpose

This study was developed as a result of conversations held with staff of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in 1985. At that time the Center for Residential and Community Services (CRCS) was reporting data from its 1982 national census study of residential services for persons with mental retardation. CRCS had also just been funded by the Administration on Developmental Disabilities to conduct a more detailed comparative study of representative samples of specially licensed foster care homes and small group care facilities (6 or fewer residents). The statistics on specialized foster care in the 1982 national census study, and the effort that CRCS was undertaking to expand its basic survey data with a comprehensive data set, brought

indirect attention to the lack of similar data on the use of generic foster care for children and adults with developmental disabilities. At about the same time ASPE personnel were involved in a set of activities related to constructing a national foster care data base. Because of the complementary, if not overlapping foster care systems, a meeting was held with CRCS and ASPE staff members to discuss the use of these two models of foster care, particularly as they related to children and youth with disabilities. Within these discussions questions were raised about the extent to which generic foster care was being used to provide residential services to persons with mental retardation, the extent to which the generic and specialized systems served similar subpopulations of persons with mental retardation, and the reasons for state variations in utilization of specialized and generic foster care models. These discussions focused on the availability of CRCS data on specialized foster care, the limited availability of data on generic foster care, and on related statistics regarding changing patterns of residential care for children and youth with handicaps. CRCS data, for example, revealed that the number of children and youth (0-21 years) in mental retardation facilities decreased dramatically between 1977 and 1982, from about 91,000 to 60,000. While CRCS staff argued that this change was probably attributable to the increased availability of public school programs and community-based family support services for children and youth with handicaps, it was conceded that some portion of the change could have resulted from children, who at one time would have been placed in mental retardation facilities, entering child welfare (generic) foster care programs instead. While these discussions raised many questions of importance to policy evaluation and future direction, it was evident that there was relatively little information readily available with which to respond to them. Discussions therefore turned to how a modest survey effort could be carried out to assess the availability of basic generic foster care data and what kinds of procedures would be required to gather them from state and local agencies from which they might be available.

To carry out an exploratory study of the generic foster care system and to gather statistics from states and selected counties, ASPE provided modest supplemental funding to the CRCS study of specially licensed foster care and small group homes. In addition to reporting on state systems with respect to persons with mental retardation and other developmental disabilities, ASPE staff members requested that information and available statistics also be gathered on children and youth with other handicaps in generic foster care, on nonhandicapped children and youth in generic foster care, and on adults with handicaps in generic foster care.

The Center began gathering background data from states in late 1985, gathered data on the number of children in homes as of December 31, 1985 during the first half or 1986, and continued with follow-ups to states throughout 1986. Among the specific purposes of the study were the following: 1) to determine the different types of information gathered and aggregated by different states regarding persons with mental retardation, persons with other handicapping conditions, and persons without handicaps in generic foster care programs; 2) to gather information available from states on the nature of the handicapping conditions of individuals living in the generic foster care homes; 3) to determine changes in the number of total children and handicapped children in the generic foster care nationally (through comparison to previous surveys); and 4) to the extent that desired information was not readily obtainable, to suggest methods by which such data might be gathered in the future.

Previous Research

Since 1960 there have been several national surveys of children in generic foster care. Notably each employed a somewhat different methodology, used somewhat different inclusion criteria, and was operationalized with somewhat different definitions. These studies are briefly described in the following paragraphs.

Jeter, 1961. Data in this 1961 survey of social services (Jeter, 1963) were based on a national sample of 49,838 case records (out of 377,000 children) receiving public social services and 12,368 (of an estimated 125,000) children receiving private social services. Of the total of 502,000 children (all but 700 were age 0-20), an estimated 233,440 were in foster care, excluding placements with parents or relatives (collected, but not included here). This estimate included both public and private (voluntary) social service agencies. Seven percent of children receiving services were mentally retarded. Of all children in foster care, 6.7% were reported to be mentally retarded.

Westat, 1977. The Westat study (Shyne & Schroeder, 1978), based on a national probability sample of 315 local agencies, included 9,597 case records of children less than 18 years in substitute care on a single day during the first quarter of calendar year 1977. This study included children in public or private care for whom the primary state child welfare agency had case management responsibility. Of 1,800,000 children receiving services, 503,000 were in substitute care, excluding those with parents, relatives, emergency shelter, or detention centers (reported separately). Mental retardation was reported for 4.7% of children, of whom between 28% (the proportion for all children) and 67% (the proportion for children with mental retardation as primary problem) were in foster care.

OCR, 1980. The Office for Civil Rights study (OCR, 1981) was a national census that included 2,436 of 2,439 local child welfare agencies (mostly counties) in the U.S.[1] The survey gathered data on all children in the legal custody of child welfare agencies as of January 7, 1980, including the number of children by race, handicap, and type of placement. Children in various types of placements made by or under the supervision of each local child welfare agency numbered 301,943, including "independent living," defined

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[1]In one state, Oklahoma, the state agency provided statewide data. In all other states, each county reported individually.

by OCR to include placement with relatives; 267,000 excluding independent living. Of children and youth with mental retardation on agency caseloads, 59% were in foster care. Of all children in foster care, 24% were handicapped; 8% were mentally retarded.

Maximus, 1982. The Maximus, Inc. study (1983) was a national probability survey of 167 child welfare agencies. Data were extracted from 4,225 case records of children less than 18 years old who were in substitute care on December 15, 1982. Of the estimated approximately 202,000 children in foster care, (not counting placement with parents, relatives, final adoptive parents, or independent living which were reported separately) 57,300 were estimated to be handicapped.

For reporting handicapping conditions, defined in a case-specific questionnaire as "physical, psychological, or mental handicap," some agencies may have used their own "agency criteria" which varied widely and in some states included broad "special needs" categories. Over 60 percent of handicapped children were over 11 years old. Of the children in substitute care who were handicapped, over 60 percent had been in care for more than two years, as compared with only 38 percent of nonhandicapped children. Almost 30 percent of all children with handicaps were living in either group homes or institutions, while only 13 percent of children without handicaps lived in group homes or institutions. There was virtually no difference in the racial distribution between handicapped and non-handicapped children.

VCIS, 1982 and 1983. In 1982, the American Public Welfare Association implemented the Voluntary Cooperative Information Systems (VCIS) to collect annual information about children less than 21 years old in substitute and adoptive care. For fiscal years 1982 and 1983, respectively, primary child welfare agencies in 48 and all 50 states and DC responded with aggregated information on out-of-home placements, although not all states responded to all items. The VCIS reports indicated that 21.1% of the children in fiscal year 1982 and 22.3% in 1983 were reported to have one or more disabling conditions

(Tatara & Pettiford, 1983,1985). Types of disabling conditions and the types of placements in which handicapped children lived were not reported.

In the studies outlined above, as well as in the present study, there have been problems in defining "foster care" (e.g., should children in detention homes be included; should children placed with relatives be included), in defining types of foster care placement (e.g., foster family home, foster group home), and in defining types of handicaps (e.g., what is a "special need"). While efforts were made in the present study to use definitions that permit comparison to earlier data, and indeed even contemporaneous comparison among states, some incongruencies remain. Even when decisions are made with respect to what should be considered to be foster care, it becomes readily apparent that some states have difficulty providing estimates of the total number of children in various types of substitute care, much less the number of children with handicaps. In summary, then, the survey attempted to identify and structure as best it could the contemporary organization and status of data systems on children and youth in foster care, including children and youth with various handicaps. It encountered many problems in attempting to rectify state data systems and their various data elements and operational definitions. Despite these problems, existing state data bases have quality with contemporary utility and which, with modest modifications, could provide even more useful statistics to inform foster care policy. This report, in addition to tabulations of the statistics gathered as part of the survey, discusses areas in which promise exists for enhanced, policy-relevant foster care data collection without undertaking major agency surveys such as those identified earlier in this report.

II. Methodology

A series of surveys were carried out in order to understand state policies on generic foster care use, to identify and gather current statistics available from states, and to examine alternatives for cost effective, ongoing collection of basic foster care data. These included a telephone interview and three questionnaire surveys directed to various state agencies, and a questionnaire survey of selected county social service agencies. These are described below.

Survey Design

State agency surveys. In the fall of 1985, a preliminary telephone survey of all 50 states and the District of Columbia was conducted by Project interviewers prior to mailing the state agency questionnaires. The purpose of the telephone contacts was to identify knowledgeable individuals in each of three state agencies (child welfare, adult services and mental retardation/developmental disabilities) from general agency listings, and to determine through these individuals the types of foster care information available from each state agency and the most knowledgeable "key contact(s)" in each agency regarding policy and population statistics. This preliminary survey was essential to the development of a standardized set of questions and definitions for gathering data across states.

In the spring of 1986, three questionnaires were mailed to each of the 50 states and the District of Columbia. One questionnaire was mailed to each state's primary child welfare agency. It requested information on the number of children and youth in foster care by type of residential settings and by type of handicap. It also included questions about the number and type of data elements contained in the state's substitute care management information system (MIS), as well as questions regarding statewide foster care policies, interagency cooperation/coordination issues, and differences between social services and mental retardation/developmental disabilities agencies regarding foster care practices.

A second questionnaire was mailed to key contact persons in adult services offices of the state social services agency. It asked questions about the use of adult foster care in the state, including the number of adults in foster care, whether programs were generic or whether they were operated and licensed for specific target populations. Other questions were asked about data elements in the agency's MIS and interagency co-involvements and cooperation in adult foster care.

A third questionnaire, mailed to key contact persons in state mental retardation/developmental disabilities agencies, paralleled those sent to social services agencies. It asked about specialized foster care for children and adults with mental retardation/developmental disabilities, about information maintained on recipients of specialized foster care, and about interagency cooperation and program coordination.

County surveys. Based on previous national foster care studies, described above, it was anticipated that much of the information desired in this survey would not be obtainable on the state level. Because the focus of this study was not only on gathering available data, but also on reporting the status of data collection by public agencies, a second component was designed to identify and gather data available from selected counties. The purpose of the county survey was to determine the extent to which information not available on the state level could be gathered from counties and to suggest sampling strategies for gathering county data. To do this three counties were sampled in each of 10 states. Two states were selected from each of the four census regions of the country. These states were selected as being generally representative in terms of size and population. In addition, California and New York were selected in order to reflect as large a proportion of the total foster care population as possible.

Three counties were selected in each of these ten states. For the purposes of selection, counties were rank-ordered by total population and divided into three groups--large (the five most populous counties in the state), medium-size (at least 75,000 people)

and small (under 75,000 people). The second largest county in the "large" group, the middle-ranked county in the "middle" group, and the middle-ranked county of the "small" group were selected as the three representative counties. State child welfare contact people were asked to confirm that selected counties were not unrepresentative of their category of counties either demographically or in terms of their child welfare system. In the rare instance where the state key contact indicated that the county was atypical, the next lower ranking county was selected to replace it.

The survey sent to county informants asked for the same basic information as the state agency children's foster care survey, with minor adaptations to reflect the county focus. The county survey also asked about the existence of both generic and specialized adult foster care in the county, and if there was generic adult foster care, how many persons, with which types of disabilities, were in such care.

Definitions and Limitations

A major difficulty in gathering and comparing aggregated statistics on foster care derives from variations in terminology. The three areas where these are most notable are type of residence, age, and type of handicap. Examples of the problems encountered in these areas are identified below.

Type of placement. In the present study, substitute care was defined to include the following categories of residences for children and youth in foster care: family foster home, including placement with relatives who are reimbursed and pre-finalized adoptive foster homes; group home (20 or fewer residents); residential treatment/institution (21+ residents); emergency shelter; secure facility; independent living; placement with family or relatives (not considered foster care in this study); and other. (Definitions of these residential categories are included in Appendix A.).

There is considerable ambiguity in the "foster care" status of many children and youth. In this study the following distinctions were made in operationally defining foster

care status. Children placed with relatives who were not licensed or reimbursed were not considered to be in foster care. Children placed with relatives who were licensed and/or reimbursed were considered to be in foster care. Children returned to their natural families, regardless of continued monitoring by a social services agency, were not considered to be in foster care. Children in secure facilities (reformatory, detention center, locked group home) were counted if they were under the case management responsibility of a state's child welfare agency, even if the placement was made by or coordinated through a Department of Corrections. Children in private agency foster placement, but for whom the state social service agency had supervisory or review status were also included. Some states include some adopted children in their foster care data bases, but finalized adoptions were excluded from the present study.

It is important to recognize that although it is possible and, indeed, important to make semantic distinctions in defining various types of foster care placements, states and counties generally operate with their own operational categories. While efforts were made to produce reports of agency data with maximum congruence to the standard definitions developed for this survey, such efforts obviously have had some degree of error in estimation. Generally issues relating to classification of substitute care facilities more often involve the problem of defining "foster care" than the problem of defining type of foster placement.

Age. A "foster child" may be 0-17 years old in some states, but 0-20 years old in others. In this report, foster children are defined as age 17 or younger, or children age less than 21 who entered foster care before the age of 18 and remain in school full time. While some reporting problems would seem likely in the 18-20 year range, the actual number of foster children who are 18-20 years old is small (estimated to be 3-5% of all foster children) and problems incurred by states in reporting according to our request probably had little impact on the overall findings.

Handicap. The two major problems in gathering information about handicaps among foster children relate to 1) definition, and 2) reporting practices. Some states use a designation called "special needs" which may include individual disabilities, but which in some states also includes special placement needs, such as being placed with a sibling, or being placed in a certain geographic area. Special needs are not therefore always the equivalent of handicaps. Even where states employ indicators of disabilities, problems are evident. Some states use functional descriptors such as physical, emotional, or mental handicap, others use standard diagnostic descriptors with more or less standard definitions (e.g., mental retardation, visual impairment), and others use very general indicators (e.g., "learning problem" or "psychological handicap") which lack objective definitions and which make it impossible to differentiate handicaps such as mental retardation, specific learning disabilities, or emotional disturbance. While the ideal criterion for being considered handicapped in this study might have been formal clinical determination of disability by a qualified diagnostician, clinical as well as functional descriptions were frequently reported by respondents to be informally applied by case workers, foster parents, or natural parents.

Despite recognition of variability among agencies in the methods and meanings in their categories and definitions of handicaps, in this study a basic set of diagnostic descriptors of disability was used. It included mentally retarded; seriously emotionally disturbed/mentally ill; specific learning disabled; hearing, speech or sight impaired; physically or health handicapped; and other, unclassified or multiple handicaps. The definitions employed for these handicaps corresponded to those used in the Office for Civil Rights 1980 Children and Youth Referral Survey (OCR, 1981), except that physical/health handicaps were combined with "other" in the OCR study. The definitions provided to respondents for each category are provided in Appendix A. Throughout this study efforts were made to establish congruence between the definitions within state data

systems and those of this study. If no congruence could be established, handicaps were considered by be "non-classified." "Special needs" were not considered to be handicaps unless the state's definition was restricted to handicaps. Hearing, speech, or vision problems were considered to be handicaps if they were defined within MIS systems (or judged based on the MIS definitions) to be serious enough to adversely affect educational or vocational performance.

As will be noted in this report, data on foster children with handicaps are not universally available. Not all state management information systems provide for the coding of handicaps. Some states' data gathering forms have a place to code handicap for each child as a demographic descriptor, but allow optional use of the code. Other states include handicap not as a client descriptor but as one of a list of possible "reasons for placement" (permitting several reasons to be coded). Reports of number of individuals placed "because of" handicap would probably significantly undercount children and youth with handicaps in foster care because of the significant number of children with handicaps for whom placement is not primarily related to an identified disability. But even in cases where a child's disability may play a major role in the placement, the coded reason for placement (e.g., parent cannot care for child) may make it impossible to determine the role of the handicap in the placement decision. The importance of caution in assuming that the "presence" of a handicapped condition implies that condition as the cause of placement can be seen in the 1983 Voluntary Cooperative Information System (Tatara & Pettiford, 1985) which reported that among reporting states 22% of children in foster care had a disabling condition, but that only 2.6% of all foster care children were reported to have been placed in foster care because of a disabling condition.

III. Findings

Children's Foster Care

The ability of states to report number of foster children by type of foster placement, number of handicapped children, or types of handicaps varies considerably. At the most elementary level all states were able to report the total number of foster care children as of approximately 12-31-85. This section reports on numbers of foster children and on the number of foster children with handicaps. It also compares December 1985 data gathered in this study with data from previous studies, and discusses statewide management information systems that are available to provide aggregations of foster care data. It concludes with a discussion about interagency cooperation in the out-of-home care of children and youth with handicaps.

Number of Children in Foster Care

All fifty states and the District of Columbia were asked to report their number of children in foster care by type of placement and by type of handicap on or as close as possible to December 31, 1985. Table 1 shows that states reported a total of 297,069 children and youth age 0 through 20 in foster care, if independent living and placement in their own family homes were included; 261,314 if they were not. Independent living and placement with family or relatives (as defined in Appendix A) are included in tables of this report that summarize specific placement types, but unless otherwise noted, are excluded from accompanying tables. Placement with relatives are counted as foster care only if the relatives were licensed or reimbursed.

Not all states were able to provide data by type of placement, but in states that could, and excluding independent living and placement with family, approximately 77% of children in substitute care were in family foster homes, 10% in group homes (20 or fewer residents) and 13% in large residential facilities (21 or more residents). Only eight

Table 1

Total Children in Foster Care by Type of Placement: 12/31/85

State	Fos. Home	Group Home	Group 21+	Emrg. Shlt.	Sec. Fac.	Ind. Liv.	Parents or rel.	Other or NC	Total
Alabama	3,421	77	790	183		4	1,445	123	6,043
Alaska								1,171	1,171
Arizona	2,232	282	112			4			2,630
Arkansas	808	283					76	10	1,177
California	33,243	5,804	4,021			3		587	43,658
Colorado	2,000	550	1,000	100		87			3,737
Connecticut	2,318	156	1,024	96	281	106		187	4,168
Delaware	561	116	52	18	28	26			801
Dist. Columbia								2,200	2,200
Florida							2,188	7,616	9,804
Georgia	3,274	487	42	334	166			1,048	5,351
Hawaii	605	24	64	161			23		877
Idaho	511	121		44	94				770
Illinois	8,108	314	1,635		190	1,110	9,679	514	21,550
Indiana	4,046	342	823	133	46	7	847	207	6,451
Iowa	1,813		1,518	270	201	31		87	3,920
Kansas	1,631	499	204	112		21	1,203	214	3,884
Kentucky	3,035	106							3,141
Louisiana	3,508	843					1,149		5,500
Maine	1,297		152	13	15	47	166	170	1,860
Maryland	3,436		708	475	16	50	616		5,301
Massachusetts	6,014	1,493							7,507
Michigan	6,693	101	2,725	174	250	647	4,760	131	15,481
Minnesota	3,640	573	1,052	361		17	20	68	5,731
Mississippi	1,340	97	110	116	0	0	461	14	2,138
Missouri	4,828	220	882	28	27	102		577	6,664
Montana								763	763
Nebraska	1,574	282	276	59	4	51	752	130	3,128
Nevada					99		291	1,174	1,564
New Hampshire	899	38	382		61	5	555	80	2,020
New Jersey	7,033	210	985	466		151		138	8,983
New Mexico	1,762						284		2,046
New York	19,324	3,348	4,253					4	26,929
North Carolina	3,324	641	284	77	75	43	1,760	76	6,280
North Dakota	389		159						548
Ohio	6,532	667	1,864	134	66	347	5,616	549	15,775
Oklahoma	2,418	118	125	55	19	1	2	1	2,739
Oregon	2,914	146	967	274	539	19			4,859
Pennsylvania	8,857	1,367	2,984						13,208
Rhode Island	1,045	134	330	116				401	2,026
South Carolina	2,744	198	298			67			3,307
South Dakota	546	24	50						620
Tennessee								4,024	4,024
Texas								4,692	4,692
Utah	931	100	67	0	3	38	231	279	1,649
Vermont	592	140	14	41		58		36	881
Virginia	4,160		814	74		100	446	261	5,855
Washington	5,426	700							6,126
West Virginia								1,903	1,903
Wisconsin	3,601	532	744						4,877
Wyoming	435	94	132	45		13	30	3	752
U.S. Total	172,868	21,227	31,642	3,959	2,180	3,155	32,600	29,438	297,069

Note. NC = not categorized

states were unable to report the number of their total substitute care population in foster family care as a specific placement type.

In Table 2 foster care placements are indexed by state population. Nationally in 1985, there were 411 children in foster care per 100,000 children age 0 through 17 years old, with a range of from 96 per 100,000 in Texas to 1,603 per 100,000 in the District of Columbia. While notable "outliers" were identified, 42 of the 51 states fell between 250 and 650 foster care placements per 100,000 children and youth.

Table 2 also reports the proportion of all children in 1980 who were not living with either of their parents -- 4.8 percent of all children -- approximately 12 times as large as the number of children in licensed foster care in 1985. There is not a strong relationship between the number of children not living with parents and the number in foster care. For example, although the District of Columbia has both the largest proportion of children not living with parents and the largest rate per 100,000 children in foster care, Mississippi and several other states show the opposite relationship.

More detailed Bureau of Census data are available on a national (not state-by-state) basis (Bureau of Census, PL 80-2-4B). Excluding children who were themselves heads of households, 4.5% did not live with either parent in 1980. This includes 3.0% for whom a relative was head of household, 1.1% (709,682) who were not related to the household head, 0.3% (167,306) in institutions, and 0.1% (93,119) in other group quarters. The Census Bureau defines foster children as "non-relatives (under 18 years old) of the householder in households with no non-relatives 16 years old and over (who might be parents of the non-relatives under 18)." In 1980, the Census Bureau estimated that of the 709,682 children not related to the head of household, 281,053 (defined by Census as foster children) were in households that could not have also included their parents. This number, 281,053 in 1980, is somewhat larger than the 173,000 children reported by states in 1985 to be in <u>licensed</u> foster homes.

Table 2

Foster Children per 100,000 State Population Age 0 through 17 in 1985

State	State Pop. 1985	State pop. Age 0 - 17 1985	Foster Placements 1985	Foster care per 100,000 age 0 - 17	Age 0-17 not with parents 1980
Alabama	4,021	1,118	4,594	411	6.8%
Alaska	521	172	1,171	680	5.2%
Arizona	3,187	909	2,626	289	5.5%
Arkansas	2,359	653	1,101	169	5.3%
California	26,365	6,985	43,655	625	5.8%
Colorado	3,231	879	3,650	415	4.1%
Connecticut	3,174	753	4,062	540	3.1%
Delaware	622	158	775	490	5.2%
Dist. Columbia	626	137	2,200	1,603	12.2%
Florida	11,366	2,659	7,616	286	7.1%
Georgia	5,976	1,675	5,351	320	7.1%
Hawaii	1,054	290	854	295	5.6%
Idaho	1,005	322	770	239	3.5%
Illinois	11,535	3,104	10,761	347	4.3%
Indiana	5,499	1,507	5,597	371	3.6%
Iowa	2,884	772	3,889	504	2.8%
Kansas	2,450	657	2,660	405	3.4%
Kentucky	3,726	1,030	3,141	305	4.5%
Louisiana	4,481	1,360	4,351	320	7.0%
Maine	1,164	308	1,647	535	3.7%
Maryland	4,392	1,096	4,635	423	5.8%
Massachusetts	5,822	1,371	7,507	548	2.8%
Michigan	9,088	2,477	10,074	407	3.6%
Minnesota	4,193	1,133	5,694	503	2.7%
Mississippi	2,613	802	1,677	209	8.2%
Missouri	5,029	1,314	6,562	499	4.6%
Montana	826	236	763	324	3.7%
Nebraska	1,606	442	2,325	526	3.0%
Nevada	936	245	1,273	520	6.2%
New Hampshire	998	258	1,460	566	2.8%
New Jersey	7,562	1,867	8,832	473	3.4%
New Mexico	1,450	445	1,762	396	5.6%
New York	17,783	4,409	26,929	611	4.0%
North Carolina	6,255	1,625	4,477	275	6.8%
North Dakota	685	198	548	276	2.6%
Ohio	10,744	2,868	9,812	342	3.3%
Oklahoma	3,301	930	2,736	294	4.7%
Oregon	2,687	714	4,840	678	4.8%
Pennsylvania	11,853	2,888	13,208	457	3.7%
Rhode Island	968	227	2,026	891	2.7%
South Carolina	3,347	942	3,240	344	8.2%
South Dakota	708	206	620	301	3.8%
Tennessee	4,762	1,265	4,024	318	6.0%
Texas	16,370	4,897	4,692	96	5.0%
Utah	1,645	604	1,380	228	2.9%
Vermont	535	141	823	582	3.7%
Virginia	5,706	1,446	5,309	367	5.9%
Washington	4,409	1,175	6,126	521	4.1%
West Virginia	1,936	526	1,903	362	4.4%
Wisconsin	4,775	1,277	4,877	382	2.8%
Wyoming	509	161	709	441	4.4%
U.S. Total	238,740	63,624	261,314	411	4.8%

Note. State populations in 1,000's as of July 1.
U.S. Bureau of Census, State and Metropolitan Data Book 1986
U.S. Bureau of Census, Living Arrangements of Children and Adults (PC80-2-4B)
Foster placements exclude independent living and placement with family/unpaid relatives.

Foster Children with Handicaps

Type of placement. Thirty two states reported statistics on the number of children and youth with handicaps in foster care. These included 25 states that could provide (or reasonably estimate) placements of all children and youth with handicaps by type of substitute care (Table 3) and 30 states that provided numbers of children and youth in substitute care by type of handicap (Table 4). Tables B1 to B6 in Appendix B provide crosstabulations of type of handicap by type of foster placement for those states able to provide such breakdowns.

When compared with the foster care placements of all children, children with handicaps were less likely to be living in family foster care settings. Excluding placements in unclassified residences, in independent living or in parents' or unreimbursed relatives' homes, about 75% of all children and youth and about 64% of handicapped children and youth were in family foster care. Children with handicaps were considerably more likely to be in group residences with 21 or more residents than were non-handicapped foster children (24% versus 14%, excluding unclassified residences, independent living, and relatives' homes).

Type of Handicap. About two thirds of states were able to provide breakdowns of their populations of children and youth with handicaps into three or more categories of disability, although most diagnoses were reported as "other" or unclassified (18,110 with 12,324 coming from New York and California). Among the approximately 25,000 children and youth with handicaps in states that reported type of handicap, approximately 8,400 (33%) were categorized as mentally retarded and 9,600 (38%) as emotionally disturbed. Perhaps more notable than the number of individuals in the different categories was the wide variability among states. This variability appears due to two primary factors. First, differences in classification procedures clearly exist. States differ in whom they report

Table 3

Handicapped Children in Foster Care by Type of Placement: 12/31/85

State	Fos. Home	Group Home	Group 21+	Emrg. Shlt.	Sec. Fac.	Ind. Liv.	Parents or rel.	Other or NC	Total
Alabama	316	5	92	2		2	65	61	543
Alaska									
Arizona	928	117	47						1,092
Arkansas								453	453
California	3,356	1,260	625					124	5,365
Colorado	385	95	135	10		18			643
Connecticut	236	29	391	19	133	26		78	912
Delaware									
Dist. Columbia									
Florida	17	4	85	6		1	26	110	249
Georgia	998								998
Hawaii	75	4	15	2			23		119
Idaho								130	130
Illinois	460	49	329		20	72	662	31	1,623
Indiana	1,118	150	417	54	19	4	242	145	2,149
Iowa	347		738	30	8	1		37	1,161
Kansas	483	307	218	52		6	284	112	1,462
Kentucky	719								719
Louisiana	561	134					152	33	880
Maine									
Maryland	956		505	89	8	9	181	2	1,750
Massachusetts									
Michigan	836	7	543	26	43	88	364	24	1,931
Minnesota								2,058	2,058
Mississippi								288	288
Missouri	1,502	122	597	7	9	35		204	2,476
Montana								249	249
Nebraska	837	185	201	33	3	25	401	75	1,760
Nevada								748	748
New Hampshire									
New Jersey									
New Mexico								162	162
New York	3,840	1,125	1,991					3	6,959
North Carolina	169	8	60	2	11	4	42	14	310
North Dakota									
Ohio	2,094		1,166				1,480	321	5,061
Oklahoma	267	2	116		19	1		1	406
Oregon	736	16	180	39	89	2			1,062
Pennsylvania									
Rhode Island								549	549
South Carolina									
South Dakota									
Tennessee	920								920
Texas									
Utah	177	24	31		1	8	28	74	343
Vermont	51							198	249
Virginia	715		293	5		28	42	32	1,115
Washington								474	474
West Virginia									
Wisconsin	258	20	88						366
Wyoming									
Reported	23,357	3,663	8,863	376	363	330	3,992	6,790	47,734

Note. NC = not classified
For estimated U.S. total, see Table 6.

Table 4

Handicapped Children in Foster Care by Type of Handicap: 12/31/85

State	Mentally Retarded	Emot. Dist/MI	Sp. Learn Disability	Hear/Sight Speech	Physical or Health	Other or NC	Total
Alabama	337	51			88		476
Alaska							
Arizona	54	856			160	22	1,092
Arkansas	121	217		4	105	6	453
California						5,365	5,365
Colorado	625						625
Connecticut	40	608		18	53	167	886
Delaware							
Dist. Columbia							
Florida	59	120		27	16		222
Georgia	254	289	71		141	243	998
Hawaii	54	21	15		6		96
Idaho						130	130
Illinois	231	232	34	27	50	315	889
Indiana	355	856	141	179	334	38	1,903
Iowa	462	307	42	171	90	88	1,160
Kansas	172	175	195		130	500	1,172
Kentucky	206	373			140		719
Louisiana	290	176	73	33	132	24	728
Maine							
Maryland	151	776	416	21	92	104	1,560
Massachusetts							
Michigan	138	804	146	52	110	229	1,479
Minnesota	1,009	351	180	150	181	187	2,058
Mississippi	107	78	53	50			288
Missouri	787	701	762		191		2,441
Montana						249	249
Nebraska	106	203	151	19	93	762	1,334
Nevada	43			31	100	574	748
New Hampshire							
New Jersey							
New Mexico	53	51	5	8	38	7	162
New York						6,959	6,959
North Carolina	123			31	62	48	264
North Dakota							
Ohio	557	899	1,222			903	3,581
Oklahoma	140	86	25	35	55	64	405
Oregon	269	613	35	41	35	67	1,060
Pennsylvania							
Rhode Island	102	337	72	38			549
South Carolina							
South Dakota							
Tennessee	244	316			137	223	920
Texas							
Utah	125	59	63	9	51		307
Vermont	51					198	249
Virginia	422					623	1,045
Washington	474						474
West Virginia							
Wisconsin	217	87		8	39	15	366
Wyoming							
Reported	8,378	9,642	3,701	952	2,629	18,110	43,412

Note. Table EXCLUDES independent living and placement with parents/unpaid relatives.
NC = not classified
For estimated U.S. totals, see Table 6.

in categories such as emotional disturbance and specific learning disabilities which in turn accounts for significant differences in prevalence among states. Second, the number of children and youth reported in a specific disability category was clearly affected by the state-county relationship in out-of-home residential placements. For example, Minnesota, in which the state mental retardation system has been exclusively committed to staffed group residences, relies heavily on child welfare services to identify and make foster care placements for children and youth. Consequently Minnesota has an extremely high number of "generic" foster care placements of mentally retarded children. Michigan on the other hand has a regional mental retardation program that includes considerable use of specialized family foster care arrangements for children as well as adults with mental retardation. Because of the development of its specialized foster care program, Michigan has relatively low utilization of "generic" foster care for children and youth with mental retardation.

Longitudinal Trends in Foster Care

Table 5 presents basic longitudinal statistics from the previous national studies of foster care utilization. These are discussed below in terms of the total population of children and youth in foster care, the placements of those children and youth, and the populations of children and youth with handicaps in substitute care.

Total population. As noted earlier in this report there have been several previous research efforts focussed on the number and, in some instances, the characteristics of children and youth in generic foster care settings. These studies, which span the approximately 25 years from 1961 to December 31, 1985 (the present study), have considerable usefulness in longitudinal analyses of changing patterns of foster care utilization. There are, however, limitations to their direct comparison. The first of these limitations is that the studies are based on three substantially different methodologies. Three of the studies (Jeter, 1963; Westat, 1978; & Maximus, 1983) drew nationally

Table 5

Approximate Number of Children in Substitute Care: 1961 - 1985

Study	Survey Year	Child Age	Family Foster Home	Total Substitute Care	Placements per 100,000 age 0-17	Mentally Retarded Children	Total Handicapped Children
Jeter	1961	0-20	169,450	233,440	362	15,731	
Westat	1977	0-17	394,000	503,000	768	36,272	
OCR	1980	0-17	197,589	266,584	419	21,410	63,643
Maximus	1982	0-17	144,767	201,847	321		57,303
VCIS	1982	0-20	180,720 a	251,000 a	400		52,961
VCIS	1983	0-20	186,431	254,687	407		56,795
CRCS	1985	0-20	192,066 b	261,314	411	13,891 c	53,566 c

Note. Refer to text for important accompanying information.
Data are adjusted, if possible, to exclude independent living, placements with family or relatives, and finalized adoptions.
VCIS and CRCS data may include some relative foster homes.
Jeter and Westat reports of other handicaps could not be unduplicated.
Maximus and VCIS did not report specific handicaps.

a For comparability, these two numbers are actually VCIS 1983 begin of year.
b Includes estimated proportion of total for 8 states.
c Includes estimates from Table 6.

representative samples of local agencies and case records. One of the surveys (Office for Civil Rights, 1981) gathered aggregated client data from virtually every county in the U.S. The Voluntary Cooperative Information System (VCIS [Tatara & Pettiford, 1985]) and the present study gathered aggregated data from state agencies. In addition to methodological differences, each study also used slightly different definitions of placement types. Finally, as noted above, there are differences among states in defining foster children. Therefore, some caution must be used in examining the summary of statistics from research on foster care presented in Table 5.

In general it appears that the number and rate of placement of all children and of handicapped children in foster care has been fairly stable over the past quarter century. Two "outlier" studies that challenge this conclusion, Westat and Maximus, were sample

studies based on samples of local welfare agencies (Westat sampled 315 of 2,439 local child welfare agencies; Maximus 167 of 2,439). The major challenge to these studies is simply that comprehensive surveys of social services agencies conducted at nearly the same time (OCR and VCIS) indicate very different numbers of children in foster care settings. The Westat estimate of the national population of children and youth in foster care was 503,000. This compares with the Office for Civil Rights survey of 2,436 of the 2,439 local jurisdictions which indicated barely half that number in foster care (266,600). It seems likely that while the Westat local jurisdictions were "representative" with respect to the factors by which they were selected, they were probably not representative with respect to foster care utilization.

The second outlier study was the 1982 Maximus study, also based on a sample of local child welfare agencies. The 201,847 children estimated by Maximus to be in foster care in 1982 is significantly less than the 266,584 reported by the Office for Civil Rights two years earlier and the 251,000 reported for essentially the same time period (the beginning of FY 1983) in the VCIS survey. (Note that unless otherwise specified, data from all studies cited have been adjusted to exclude foster children living at home [with natural parents], independently, or with unpaid relatives.) Therefore, it seems reasonable to assume that Maximus significantly underestimated the number of children and youth in foster care. Based on participating 167 local agencies that reported 17.6% fewer children than reported to OCR two years earlier, Maximus estimated a similar decrease in the 2,269 nonparticipating agencies (with about 70% of all foster children in the OCR survey). It would appear that this procedure underestimated the number of children in foster care. One other variation between VCIS, the present study, and the Maximus survey was the inclusion in the former two of some children age 18, 19, and 20 years old who had been placed in foster care before age 18. The 1983 VCIS survey estimated 7,000 such youth.

We conclude that the number of children in foster care at any one time has been fairly stable since 1961. Substitute care placements of children and youth increased from about 233,400 (362 per 100,000 children birth to 17 years old) in 1961 to 266,584 (419 per 100,000) in 1980. Since 1980 there has been considerable stability in placement rates with state surveys showing 251,000 (400 per 100,000) in October 1982, 254,700 (407 per 100,000) in September 1983, and 261,300 (411 per 100,000) in December 1985.[1]

The number of handicapped children in foster care requires some estimation because, as noted earlier, not all states record handicaps and those that do often do so under different definitions. What is more, for the sake of longitudinal comparisons, the earliest data on total placements of children with handicaps in foster care is 1980. The Jeter and Westat studies (prior to 1980) did gather information on handicaps, but did not present crosstabulations of handicap by type of service/placement.[2] Based on the best data states were able to provide and proportional estimates for missing data, the number of children with handicaps in generic foster care decreased from 63,643 to 53,566 between 1980 and 1985. It appears that much of this decrease was related to decreasing numbers of children and youth with mental retardation in generic foster care, from about 21,400 in 1980 to approximately 13,900 in 1985. While the decrease in the reported number of mentally retarded children and youth in foster care between 1980 and 1985 appears particularly dramatic, the amount of decrease (35%) was virtually identical to the 34%

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[1]A special state-by-state presentation of VCIS 1984 data prepared for the Administration for Children, Youth, and Families (Maximus, 1984) reported 255,759 children in foster care, excluding those living with their own parents. Preliminary VCIS 1985 data provided by ACYF indicate approximately 255,000 children in foster care (adjusted to exclude an estimated 7.3% of children who live in their own [parents'] homes).

[2]A special analysis of Westat 1977 data completed by MacEachron and Krauss (1983) focussed on handicapped children in the sample. They presented data on the proportion of children whose primary reason for receiving service was either mental retardation or emotional disturbance or a physical handicap by type of foster placement. However, a nonreported number of additional children (not necessarily in like proportion by type of residence) had handicaps that were not the primary reason for receiving services.

decrease in mentally retarded children and youth in mental retardation residential facilities over the five year period between 1977 and 1982 -- from 91,000 on June 30, 1977 to about 60,000 total on June 30, 1982 (Hill, Lakin & Bruininks, 1984). Some of this decrease may correspond to the fact that during this time the public school system has labelled fewer children as mentally retarded and more as learning disabled. But irrespective of the particular type of handicap ascribed to individuals, the general decrease in the number of all handicapped children in foster care (all diagnoses) must also be attributed to improved efforts to provide support and needed services to handicapped children and youth and their natural families.

State-by-State Changes in Foster Care Placements

For the purposes of establishing a comparative base for examining the data gathered in the present study, the 1980 Office for Civil Rights foster care study was selected. The OCR study included mandatory participation by all local child welfare agencies in the country, it used a uniform set of acceptable definitions after which the present study's definitions were modeled, and it defined special needs as a "*clinically* diagnosed handicap" (emphasis in original). Also of importance to comparability, OCR presented its data on a state-by-state basis.[1] Table 6 compares OCR and CRCS data by state, for total number of children, for children who are mentally retarded, and for children with any reported handicap. Although these data are presented for comparative purposes, caution is warranted. The CRCS survey collected its statistics from state agencies, whereas OCR gathered data from local agencies. Indeed as part of the CRCS state child welfare agency survey the 1980 OCR numbers for each state were supplied to respondents who were asked whether they felt the number had increased or decreased by 1985. Several state

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[1]Although the American Public Welfare Association's VCIS reports present only national totals, Maximus, Inc. (1984) prepares state-by-state reports of VCIS data for the Administrations for Children, Youth, and Families. These reports do not provide numbers of handicapped children.

respondents indicated that the OCR statistics for 1980 seemed too high or too low. Additionally, the data from the CRCS survey included a small but unknown number (probably a few thousand nationally) of youth aged 18 to 20 who were placed before age 18 and who remain in foster care; OCR statistics include age 0-17 only.

In Table 6 estimates for states which were unable to provide 1985 data on mentally retarded and handicapped populations were imputed in proportion to the change from 1980 in reporting states. As Table 6 indicates, the total number of children in all three categories decreased nationally, but there was considerable variation from state to state, with 23 states reporting an increase, and 27 states and DC reporting decreases.

Regarding all children in foster care, between 1980 and 1985 most states (29) showed decreases. Most noticeable among states with decreasing foster care populations was New York, where the number of foster children decreased by 10,000 over the 5 year period. Net decreases in a number of states since 1980 were largely counterbalanced by California, which reported an increase of nearly 20,000 children in substitute care. State and federal officials expressed confidence in the accuracy of California's data, but are unsure of the reason for the increase. Both California and Georgia, another state reporting an increase, speculated that greater attention to and reporting of child abuse, and, (in California) a backlog in the court system regarding parent custody and adoption proceedings, may account for some of the increases.

The number of handicapped children and mentally retarded children also decreased between 1980 and 1985. Including estimates of children and youth with mental retardation in states unable to provide actual figures, 5.4% of all foster children were estimated to be mentally retarded. Of the 33 states actually reporting mentally retarded populations, 5.9% of all foster children were reported to be mentally retarded. Variations among states were substantial, ranging from 17.7% in Minnesota to less than 1% (0.8) in Florida. As noted earlier in another context, such variations are often administrative in

Table 6

Children in Foster Care: 1980 and 1985

	All Children		MR Children			All Handicaps		
	OCR 1980	CRCS 1985	OCR 1980	CRCS 1985	Pct. all 1985	OCR 1980	CRCS 1985	Pct. all 1985
Alabama	4,392	4,594	431	337	7.3%	932	476	10.4%
Alaska	662	1,171	25	19 e	1.6%	75	65 e	5.6%
Arizona	2,170	2,626	224	54	2.1%	1,173	1,092	41.6%
Arkansas	1,321	1,101	120	121	11.0%	325	453	41.1%
California	24,402	43,655	1,718	1,280 e	2.9%	9,776	5,365	12.3%
Colorado	4,033	3,650	359	625	17.1%	1,426	1,236 e	33.9%
Connecticut	3,954	4,062	307	40	1.0%	882	886	21.8%
Delaware	894	775	51	38 e	4.9%	184	159 e	20.5%
Dist. Columbia	2,731	2,200	152	113 e	5.1%	854	740 e	33.6%
Florida	9,389	7,616	608	59	.8%	1,722	222	2.9%
Georgia	4,530	5,351	494	254	4.7%	1,124	998	18.7%
Hawaii	408	854	16	54	6.3%	101	96	11.2%
Idaho	765	770	34	25 e	3.2%	192	130	16.9%
Illinois	8,656	10,761	275	231	2.1%	794	889	8.3%
Indiana	6,403	5,597	475	355	6.3%	1,262	1,903	34.0%
Iowa	2,732	3,889	527	462	11.9%	1,012	1,160	29.8%
Kansas	3,941	2,660	2,667	172	6.5%	3,394	1,172	44.1%
Kentucky	4,076	3,141	372	206	6.6%	853	719	22.9%
Louisiana	5,244	4,351	622	290	6.7%	1,271	728	16.7%
Maine	1,697	1,647	108	80 e	4.9%	384	333 e	20.2%
Maryland	7,017	4,635	85	151	3.3%	482	1,560	33.7%
Massachusetts	8,459	7,507	310	231 e	3.1%	1,765	1,530 e	20.4%
Michigan	9,904	10,074	402	138	1.4%	1,787	1,479	14.7%
Minnesota	7,261	5,694	1,229	1,009	17.7%	2,598	2,058	36.1%
Mississippi	2,136	1,677	243	107	6.4%	427	288	17.2%
Missouri	6,191	6,562	374	787	12.0%	1,335	2,441	37.2%
Montana	816	763	79	59 e	7.7%	192	249	32.6%
Nebraska	2,326	2,325	128	106	4.6%	357	1,334	57.4%
Nevada	717	1,273	5	43	3.4%	39	748	58.8%
New Hampshire	1,289	1,460	65	48 e	3.3%	222	192 e	13.2%
New Jersey	9,496	8,832	506	377 e	4.3%	2,761	2,393 e	27.1%
New Mexico	1,194	1,762	76	53	3.0%	213	162	9.2%
New York	37,596	26,929	2,548	1,898 e	7.0%	7,570	6,959	25.8%
North Carolina	6,185	4,477	507	123	2.7%	1,151	264	5.9%
North Dakota	456	548	40	30 e	5.5%	85	74 e	13.5%
Ohio	13,484	9,812	894	557	5.7%	2,761	3,581	36.5%
Oklahoma	2,061	2,736	195	140	5.1%	577	405	14.8%
Oregon	5,068	4,840	268	269	5.6%	1,177	1,060	21.9%
Pennsylvania	14,435	13,208	731	545 e	4.1%	1,606	1,392 e	10.5%
Rhode Island	1,593	2,026	46	102	5.0%	152	549	27.1%
South Carolina	3,193	3,240	264	197 e	6.1%	654	567 e	17.5%
South Dakota	746	620	63	47 e	7.6%	169	146 e	23.5%
Tennessee	4,329	4,024	375	244	6.1%	890	920	22.9%
Texas	5,362	4,692	494	368 e	7.8%	1,487	1,289 e	27.5%
Utah	1,275	1,380	56	125	9.1%	364	307	22.2%
Vermont	685	823	31	51	6.2%	150	249	30.3%
Virginia	8,089	5,309	906	422	7.9%	2,779	1,045	19.7%
Washington	4,120	6,126	152	474	7.7%	736	638 e	10.4%
West Virginia	2,530	1,903	199	148 e	7.8%	483	419 e	22.0%
Wisconsin	5,835	4,877	540	217	4.4%	846	366	7.5%
Wyoming	336	709	14	10 e	1.4%	92	80 e	11.3%
U.S. Total	266,584	261,314	21,410	13,891	5.3%	63,643	53,566	20.5%

Note. Data EXCLUDE independent living and placement with parents/unpaid relatives.
OCR date from Office of Civil Rights 1980 Children & Youth Referral Survey
Estimates (e) were proportionate to changes in reporting states except KS between 1980 and 1985.

nature. Minnesota until recently had no specialized foster care (i.e., licensed or funded by its Division of Mental Retardation) so that all children with retardation were included in the current study. Florida, on the other hand, has developed a carefully coordinated state program of specialized foster homes where nearly all foster children with mental retardation are placed; therefore less than 1% of children in child welfare foster homes in Florida are mentally retarded. Statistics reported by states on children with all types of handicaps varied considerably in both the types of handicaps included and the populations of children in foster care with handicaps. The national average prevalence of handicaps among foster children was 20.5%, with a range of from about 3% in Florida to 58% in Nevada. Eleven of 35 states supplying data indicated that 33% or more of the children and youth in foster care were handicapped. Ten states indicated less than 15% of the children in foster care were handicapped. Generally then, the prevalence of handicaps among children and youth in foster care is estimated to be about double that reported among the school age population as a whole.

Statewide Management Information Systems for Children

Based on in this survey, it seems that data on foster care populations can be systematically gathered from states at relatively low cost. However, in making comparisons between reports of these populations from states and those from counties as reflected in the OCR data, questions of reliability of are obviously raised. Certainly the fact that several states surveyed directly questioned the OCR aggregation of local social service agency reports raises further questions. In Kansas in 1980, for example, counties reported that 3,394 of 3,941 children in foster care (86%) were handicapped. Most counties reported that all foster children were handicapped. In 1985, the Kansas computerized Child Tracking System indicated that only 44% of foster children were handicapped, a more plausible figure because it is unlikely that there were only 547 nonhandicapped Kansas foster children in 1980.

Although at the present time there is insufficient standardization of definitions of handicaps and of placement types, the present survey has suggested potential for recurring aggregation and comparison of state data. Special analyses of data on handicapped foster children may already be possible from MIS data elements currently maintained by over half the states. In a few more states additional handicap categories could adapt the existing system for such a use. Given the current data collected in about 20 states it would be necessary to gather information on handicapped children directly from counties. This section examines state foster care data reporting abilities and also looks at alternatives for improving or supplementing the existing potential of states.

States differ tremendously in the capabilities of the systems they have developed to meet the data collection requirements of P.L. 96-272. At one extreme, one state (Idaho) accomplishes such reporting by monthly regional reports, manually tabulated. Three states use their foster care payment system to monitor the numbers of children in foster care. At the opposite extreme, there are states that have comprehensive on-line computerized client tracking and billing/reimbursement systems through which all counties and/or state regional offices operate.

Table 7 presents summary information on the status of statewide management information systems (MIS) for children and youth in foster care. Although 43 of the 51 states (including the District of Columbia) reported a computerized information system for tracking children and 43 of 48 states reporting the periodicity of case updates indicated they occurred at the time of program changes, the types of information contained in state MIS's vary tremendously. Two of the most important information components for the purpose of this study regarded the way in which handicaps were recorded.

Handicaps. Following preliminary interviews which identified the general manner in which states categorize handicaps, each state was surveyed to gather specific information

Table 7

Children's Foster Care: Management Information Systems

State	MIS	Maintained Manually Computerized or by Survey	Freq. of Update	Handicap Recorded: As Specific Diagnosis	As Y/N	Plcmnt Reason	Not Rec.
Alabama	Y	C	CC	X			
Alaska	Y	C	CC				X
Arizona	Y	C	CC	X			
Arkansas	Y	M, C	CC, Other	X		X	
California	Y	C	CC		X	X	
Colorado	Y	C	CC, Mnthly	X			
Connecticut	Y	C	CC		NR		
Delaware	Y	C	NR				X
Dist. Columbia	Y	C	CC			X	
Florida	Y	C	CC	X			
Georgia	Y	C	CC		X		
Hawaii	Y	C	CC		X	X	
Idaho	Regional repor	M	Mnthly		NR		
Illinois	Y	C	CC	X			
Indiana	Y	C	Wkly	X			
Iowa	Y	C	CC	X		X	
Kansas	Y	C	CC	X			
Kentucky	Y	C	Mnthly				X
Louisiana	Y	C	CC	X			
Maine	Y	C	CC				X
Maryland	Y	C	CC		X		
Massachusetts	NR	NR	NR		NR		
Michigan	Y	C	CC	X			
Minnesota	Y	C	CC	X			
Mississippi	Y	M	CC	X			
Missouri	Y	C	CC	X			
Montana	Y	C	CC			X	
Nebraska	Y	C	CC	X			
Nevada	Payment system	C	Mnthly	X			
New Hampshire	Y	C	CC		X		
New Jersey	Y	C	CC		Opt.		
New Mexico	Y	M, C	Qrtly		Opt.		
New York	Y	C	CC			X	
North Carolina	Y	C	CC	X			
North Dakota	Payment system	S	Mnthly	X			
Ohio	Y	C	CC, Yrly	X			
Oklahoma	Y	C	CC	X			
Oregon	Y	C	CC			X	
Pennsylvania	Y	C	Qrtly				X
Rhode Island	Y	C	CC	X			
South Carolina	Y	M, C	CC	X			
South Dakota	Y	C	CC				X
Tennessee	Y	C	CC	X		X	
Texas	Y	C	CC	X			
Utah	Y	C	CC	X			
Vermont	Y	C	CC		X		
Virginia	Y	C	CC		X		
Washington	Y	C	CC	X			
West Virginia	Y	C	CC			X	
Wisconsin	Y	C	CC	Opt.	X		
Wyoming	Payment system	M	Mnthly				X

Note. NR indicates no response to an item.
CC indicates records updated with any case change.

on whether its MIS treated handicap as a simple "yes/no" for all children, as a diagnostic item with subcategorizations, or as a reason for placement, and whether this information was expected to be universally reported or was optional. Eight of the 47 states for whom MIS characteristics for recording handicaps are summarized in Table 7 reported that they gather no data on handicapping conditions. Twenty-eight states record handicap as a standard demographic item, (i.e., type of handicap, if any, is a data element collected on all foster children regardless of reason for placement). Fourteen of these 28 states indicated that when handicap is recorded, the specific diagnosis is included. Three states indicated that recording of handicapping condition is optional, or required only in certain circumstances. New Jersey, for instance, indicates that recording of handicaps is optional except when the information is needed because of a specific funding source or special program.

Eight states reported that "handicap" or type of handicap is recorded as being among one or more reasons for placement/service, or as relevant to the type of service needed; however in only four of these states would this be the only circumstance under which handicaps were recorded. Recording handicap only as a "reason for placement" underestimates the incidence of handicaps among children in foster care because although a child may be handicapped, the actual reason for placement in foster care might be coded as "abuse," "neglect," "family dysfunction," etc.

A third way in which a few states allude to handicaps is to code broad categories such as "special needs," or "learning problem," which again may be treated either as a demographic item or as a reason for placement. These data are extremely difficult to interpret because there are no standard definitions regarding what types of handicaps, other conditions or life circumstances constitute a special need or learning problem.

Table 8 reports the type of handicapping conditions coded in the MIS of the various states. Twenty-five of the 27 states that record specific categories of handicap include mental retardation or developmental disabilities. Of these 25, 6 distinguish among levels or degrees of retardation. Twenty-one states' MIS forms ask about emotional disturbance or mental illness, 5 about nature or degree. Twenty-five inquire about physical handicaps, 6 about nature or degree. Eight states ask about substance abuse or chemical dependence, 6 about speech impairment, 11 about a vision or hearing impairment, 11 about a neurological disorder or learning disability, 8 about multiple handicaps, and 11 have other categories. The number of types of handicapping conditions, if recorded, varies from one ("special needs") in Georgia to 16 in Wisconsin.

Type of placement. Foster care is a generic term that usually includes at least four basic types of out-of-home care: family foster homes, group homes, group treatment facilities, and child caring institutions. Table 9 lists the types of substitute care that are used in various states' MIS reporting programs. Forty of the 41 states for whom this information was obtained use "family foster home" as a basic type recorded. (Arizona, the lone exception, codes placement only by the facility ID number, not by facility type.) The variety of different codes for different types of placement is large, varying from simply "foster home" to systems that include categories such as foster home with relatives, one-parent foster home, two-parent foster home, licensed foster home, unlicensed foster home, foster home with non-relatives, and others. Thirty-six states code some type of group home, 35 some form of residential treatment or institutional care, and 19 states "child caring institutions." Other frequently occurring types of care that are coded include: emergency or shelter care (28 states); secure facility or detention (16 states); own home/parents' home (16 states); relative's home (26 states); independent or semi-independent living (18 states); nursing home (13 states); facility in another state

Table 8

Children's Foster Care MIS: Types of Handicaps Recorded

State	No Response to Item	Does not Record Handicap	Other Types or as Y/N only	MR or DD	ED or Behav. Disorder or MI	Physical Handicap or Health	Substance Abuse	Speech Impair	Vision or Hearing Impair	Neuro-logical Impair or LD	Mult. Handicap
Alabama				(1)	X	X					
Alaska		X									
Arizona				X	X	(3)	X				
Arkansas				(1)	(2)	(3)			X		
California			X								
Colorado			X	X	X	X	X			X	
Connecticut	X										
Delaware		X									
Dist. Columbia	X										
Florida				X	X	X	X				
Georgia			X								
Hawaii				X		X					
Idaho	X										
Illinois			X	X	X	X		X	X	X	X
Indiana			X	X	(2)	(3)		X	X		
Iowa				X	(2)	X	X	X	X	X	
Kansas			X	X	X	(3)				X	
Kentucky		X									
Louisiana				X	X	X				X	X
Maine		X									
Maryland			X								
Massachusetts	X										
Michigan			X	X	X	X					X
Minnesota			X	(1)	X	(3)	X	X	X	X	
Mississippi			X	(1)	X	X		X	X	X	X
Missouri			X		(2)	(3)					
Montana				X	X	X					X
Nebraska			X	X	X	X			X	X	
Nevada				X	X	X		X	X	X	X
New Hampshire			X								
New Jersey			X	X	X	X					X
New Mexico			X								
New York			X								
North Carolina			X	X		X	X		X		
North Dakota				X							
Ohio				X	X	X				X	
Oklahoma				X	X	X		X	X	X	X
Oregon				X		(3)		X	X	X	X
Pennsylvania		X									
Rhode Island			X	X	X	X		X	X	X	
South Carolina			X	(1)	X	X					
South Dakota		X									
Tennessee				X	X	X	X				X
Texas				X	X	X	X		X		
Utah			X	X	X	X			X	X	X
Vermont			X								
Virginia			X	X	X	X	X	X	X	X	
Washington				X							
West Virginia			X	X		X	X		X		
Wisconsin			X	(1)	(2)	X	X		X		
Wyoming		X									

(1) Includes separate MR and DD categories
(2) Includes separate ED, BD, and MI categories.
(3) Includes separate physical handicap and health problem categories.

(6 states); and runaway (13 states). Twenty-seven states report one or more categories other than those listed.

The two placement situations which represent the greatest source incongruity among state data collection efforts appear to be in the reporting of children who are returned to their parents' home but receive post-placement follow-up, and children who live with relatives. Some states include all or some of these children in their foster care information systems, others do not. Generally, however, it was observed in this survey that almost all states that included natural family placements in their MIS programs were able to exclude such placements from their foster care client counts when requested to do so.

Finally, to evaluate the flexibility of the state MIS programs, states were requested to provide crosstabulations of number of children by type of handicap by type of placement. Approximately 50% of states were able to do so in varying degrees of completeness (see Appendix B). In states in which local social services agencies forwarded aggregated data in both categories to the state MIS system, making the local agency the unit of analysis, "client-level" crosstabulations were not positive.

Foster Care Program Operation

In addition to collecting information on and from state foster care MIS programs, a portion of the state surveys was also focused on operational aspects of foster care within various states. Areas examined in this foster care survey included foster care training requirements, case management, and interagency cooperation. Results are summarized in Table 10.

Training requirements. Eleven states indicated that they required a specific number of hours of training as pre-service to providing foster care. The requirement ranged from 6 hours in Minnesota to 21 hours in New Hampshire. Five of the eleven states required only pre-service training, with no requirements for ongoing annual training. Of

Table 9

Children's Foster Care MIS: Types of Placement

State	Fam. Fost Home	Grp Home	Resid Treat ment	Child Care Inst	Emerg Shelt Care	Secure Fac. Detent	Own Parent Home	Rel- ative Home	Run- away	Inde- pend.	Nurs- ing Home	Out of state	Other
Alabama	X	X		X			X	X	X	X	X	X	X
Alaska	X	X	X	X	X	X	X	X	X		X	X	X
Arizona													
Arkansas	X	X	X	X	X		X	X	X		X		X
California	X	X											X
Colorado	X		X				X	X	X	X			
Connecticut	X	X	X		X								
Delaware	X	X	X		X	X	X			X			X
Dist. Columbia	X	X	X	X									
Florida	X	X	X	X						X			
Georgia													
Hawaii	X	X	X		X	X		X					X
Idaho	X	X	X		X	X							
Illinois	X	X	X	X		X	X	X	X	X	X		X
Indiana	X	X	X	X	X	X	X	X	X		X		X
Iowa	X	X			X					X		X	X
Kansas	X	X	X		X								X
Kentucky													
Louisiana	X	X	X	X	X			X		X			X
Maine	X	X	X		X	X	X	X		X			X
Maryland	X	X	X	X	X								
Massachusetts													
Michigan	X	X	X	X	X								X
Minnesota	X	X	X	X	X	X	X	X	X	X	X		X
Mississippi	X	X	X	X	X			X					
Missouri	X	X	X	X	X	X		X	X	X			X
Montana	X	X	X		X							X	X
Nebraska	X	X	X	X	X	X	X	X	X	X	X		X
Nevada	X	X	X		X	X	X	X	X	X	X		X
New Hampshire	X				X								X
New Jersey	X	X	X	X	X	X	X	X	X	X			X
New Mexico	X	X	X		X			X		X		X	X
New York	X	X	X					X			X		
North Carolina	X	X	X		X	X	X	X		X	X		X
North Dakota	X	X	X										X
Ohio	X	X	X	X			X	X	X	X			X
Oklahoma													
Oregon	X	X	X		X	X		X		X			X
Pennsylvania													
Rhode Island	X	X	X		X			X					X
South Carolina	X	X		X			X	X					
South Dakota	X	X	X		X								
Tennessee	X												
Texas	X	X	X	X	X	X		X	X	X	X		X
Utah	X	X	X	X	X								
Vermont	X	X	X	X	X								X
Virginia	X	X	X		X	X	X	X	X	X	X		
Washington	X	X	X	X	X	X	X	X		X	X		X
West Virginia	X	X	X	X	X	X	X	X			X		X
Wisconsin	X	X	X	X	X	X	X	X		X	X		X
Wyoming	X	X	X							X		X	

Table 10

Children's Foster Care: Policies and Practices

State	Preservice Training Hours	Minimum Annual Training Hours	Case Management by: County	Case Management by: State	Case Management by: Priv. Agency	Generic MR/DD Same License	Inter-agency agreement	Differences in Recruitment & Selection of Generic & MR/DD Homes
Alabama		0	X				No	Yes
Alaska								
Arizona	6	6		X		No	No	Yes
Arkansas	18		X			No	No	No
California			X			Yes	No	No
Colorado	0		X			No	Yes	Yes
Connecticut								
Delaware	+	0	X			No	UD	Yes
Dist. Columbia								
Florida	18	0		X		No	Yes	No
Georgia	12	4	X			No	No	Yes
Hawaii		+		X		Yes	Yes	Yes
Idaho	+			X		Yes	No	Yes
Illinois								
Indiana		0	X			No	Yes	Yes
Iowa		12	X			Yes		Yes
Kansas		6		X		Yes	No	No
Kentucky		6		X		Yes	No	Yes
Louisiana	15		X			Yes	Yes	Yes
Maine	0 ++					Yes	Yes	No
Maryland								
Massachusetts								
Michigan								
Minnesota	6	12	X			No	No	
Mississippi			X					
Missouri		10	X				No	Yes
Montana		15				Yes	No	No
Nebraska		0		X		Yes	No	Yes
Nevada		0		X		Yes	Yes	
New Hampshire	21	16		X	X	Yes	No	No
New Jersey	10	0				Not lic.	Yes	No
New Mexico		10		X		Yes	Yes	No
New York	0	0	X				Yes	
North Carolina	County +++		X			No	Yes	Yes
North Dakota	20	12	X			Yes	No	
Ohio	County +		X			No	No	Yes
Oklahoma		21		X		Yes	Yes	Yes
Oregon		0	X	X		Yes	UD	No
Pennsylvania		6	X			No	No	Yes
Rhode Island	15		X	X		Yes	No	Yes
South Carolina	10	5	X				No	Yes
South Dakota		6	X			Yes	No	No
Tennessee								
Texas								
Utah								
Vermont								
Virginia		County +	X			No		
Washington		0				Yes	Yes	No
West Virginia								
Wisconsin		County +	X					Yes
Wyoming		20		X		Yes	No	No

\+ Training required, no min. hours specified
++ 12-18 hours proposed
+++ 10 hours proposed
UD Under development

33 states that supplied information on training, 16 required some annual training, ranging from 4 hours in Georgia to 20 hours in Wyoming. Five states indicated that requirements regarding training were established by local county agencies, and that the number of hours required varied from county to county. New York does not require training of foster parents, but requires that counties offer a certain number of hours. Maine and North Carolina indicated that a state training requirement had been proposed.

Case management. Case management for children and youth in generic foster homes is most often performed by county social services departments, although 14 states reported that case management was performed by either regional or state workers. New Hampshire indicated that area agencies are contracted to perform case management. When questioned about differences in case management or in monitoring and evaluation between generic foster homes and specialized MR/DD foster homes, most states described different administrative rules and stated that the two different types of homes are operated under different administrative statutes and regulations. In general, states indicated that MR/DD foster homes are more highly regulated, with additional safety requirements and training requirements most frequently noted. Case managers for specialized foster homes were also reported to have greater responsibilities and to be more directly involved in program planning. To provide for the higher expectations and intensities of service in the specialized programs, states reported that they were better funded, had more support services and consultation available to them, and were better supervised by agency staff.

When asked whether specialized mental retardation foster homes are required to have the same license as generic foster homes, 18 states indicated they did; twelve states indicated they did not. However, many of states that noted that the same license was required also noted that there were additional licensing requirements for specialized foster homes.

Despite the parallel purpose of specialized foster care programs (operated by Departments of Mental Retardation/Developmental Disabilities) and generic foster care programs (operated by County Departments of Social Services/Child Welfare) this survey found that in most states each Department has little knowledge of the other's program. When state child welfare and mental retardation agency personnel were asked to comment on how policies differed between generic and specialized foster homes, they frequently commented on how little they knew about differences in licensing, case management, monitoring, recruitment, and reimbursement rates among the agencies.

One reason for the lack of interprogram familiarity appeared to be because the programs operated at different levels of government. Social service programs are usually county-based, whereas specialized mental retardation programs are usually administered at the state or regional level. Indeed in some states the separateness of the programs was seen to be part of a concerted division of labor. Child welfare agencies frequently reported that severely handicapped children were referred from social services to mental retardation departments if a more specialized program and specialized providers were needed by an individual, if the financial resources available to develop an appropriate program were more readily available in the specialized program, or if there was an opportunity to recognize a financial benefit for the local social services department by doing so (i.e., if the state rather than the county would fund the out-of-home care). Finally some child welfare agencies distinguished between their role in providing temporary foster care placements versus the state's role in operating long-term care systems. If the placement of a handicapped individual was in response to a temporary need (e.g., because of family problems, an out-of-home placement lasting until a local school program was finished, or a temporary placement until an opening was available in the state long-term care system), it was generally seen as an appropriate role for the child welfare/social service agency. On the other hand, if the placement was considered

a permanent residential placement for a person with significant long-term care needs, it was much more likely to be seen as fitting the state's traditional role in providing long-term residential care.

Interagency cooperation. In the state agency questionnaires, respondents were asked if there were any formal interagency agreement regarding coordination of service between the agencies sponsoring generic and specialized mental retardation foster care. In eleven states such an agreement already existed; in twenty-one there was no such an agreement. Delaware and Oregon were reported to be in the process of establishing a formal agreement regarding coordination of foster care responsibilities and services between agencies.

In most states with existing agreements those agreements were most commonly reported to define responsibilities of the respective agencies, especially regarding referral, licensing, coordination of services, and financial accountability. In Louisiana such agreements specify the transfer of children at age 18 from child welfare to mental retardation agencies. For the most part states without such agreements did not indicate that specific problems derived from the lack of formal agreements. Six state respondents did, however, indicate problems. Two noted difficulty in establishing responsibility and clarity regarding agency roles. Two others indicated problems in coordination of service delivery, case management, and financial responsibility. Another state noted the lack of resources in the mental retardation division for foster homes for children and youth, often leaving the social services agency "holding the bag," especially regarding provision of services to profoundly retarded and multiply handicapped children. However it was noted in this state that although the mental retardation division was unable to supply enough homes for these children, it did provide training to individuals that the division of social services recruited as foster care providers.

States were asked if there were any differences in recruitment and selection of foster families for children with a handicap compared to those without. Seventeen states replied yes, and twelve replied no. Most states that described differences reported that foster parents for handicapped children were expected to have more competence, skills, and/or experience with the particular kinds of problems the children had. Also, interest, motivation, and willingness to participate in specialized training were mentioned. One state mentioned that persons who had medical knowledge and practical nursing skills were sought for handicapped children. Other considerations by one state in selection of foster homes included the number and types of children in the home, the location of the home in relation to special schools, and special medical facilities.

Differential use of generic and specialized foster homes. Respondents were given an example of an 8 year old mentally retarded boy whose family was no longer able to care for him at home. They were asked what factors would determine if he went to generic foster care, to a specialized (MR/DD) foster care home, or to a group home for persons with mental retardation. At least seven states specified that placement in a generic foster home could not be made without some type of legal/court procedure (such as charges of abuse/neglect). Other respondents indicated that placements depended on availability of homes, the referral agency that was contacted first, or the availability of funding in each agency. One respondent replied that proximity to the parents' home would be the primary deciding factor in his state.

Respondents were asked if they perceived particular incentives or advantages favoring the use of one model of foster care for children over the other, which should affect their differential use. The most common reply was that to identify one or more advantages of specialized homes for handicapped children, including that they offered better training, staff and resource linkages to special services, higher reimbursement, additional support services to providers such as respite care, and more case management

(one respondent noted the opposite relationship in her state). One state noted that specialized homes had better access to advocacy networks than did regular foster homes. Some respondents specifically argued that "[generic] foster parents do not acquire or desire to acquire the skills necessary to parent MR/DD children," that "generic foster parents do not have enough dedication for problem children," and that "more children are added daily to the system who have greater needs, for whom foster parents are not prepared or trained, resulting in a reduced quality in care and burnout." the bases of their attitudes, and their effects, would make an interesting topic of future research. Although most state replies centered on these points, there were some opposing replies. For instance, seven state respondents argued an advantage to generic foster care homes for handicapped children, indicating that these homes are better mainstreamed and are less restrictive. Specifically, they offer "integrated children's social services, integrated placements," and provide children a better opportunity "be with more normal peers" in a "more traditional family type setting," with "more opportunity for normal child development experiences" and to "more quickly pick up normal behaviors from the other children." Three respondents also argued that children in generic foster homes have a greater chance of returning to their natural home or to an adequate home in that there is a greater emphasis on permanency planning and referral for adoption from generic homes. The respondents that expressed this general view also tended to perceive specialized foster homes as too isolated, too structured, too regimented, and too specialized. Four respondents specifically noted that a problem with most specialized foster care settings was labelling or stigmatizing of residents.

In addition to these general problems associated with some specialized foster care programs, three states mentioned that recruitment for specialized homes was a problem, with one respondent observing generic homes to be more widely available in more populated areas where educational and rehabilitation services are available, and, in

another, that generic homes had the advantage of being able (by regulation) to have more children and a greater mix of children.

Most child welfare respondents who knew the reimbursement rates for both generic and specialized foster care reported higher figures for specialized homes. Respondents' reports of reimbursement rates for severely handicapped teenagers in generic foster care ranged from approximately $200 to $700 per month or from $6.50 to $23 per day, with most noting a payment range that varies by difficulty of care and age.

Trends in the use of foster care. Respondents were asked if there were any recent trends regarding the use of the generic foster care system for handicapped children, especially with regard to deinstitutionalization or to expansion of community-based services for children with handicaps. Of those venturing an option, nineteen replied yes, ten replied no. Eight states (New Jersey, Oklahoma, North Carolina, Louisiana, Colorado, South Carolina, Oregon, and North Dakota) reported that there were major deinstitutionalization efforts in their states that involved the use of generic foster care in significant ways. North Carolina's respondent mentioned that many deinstitutionalized individuals have been placed into generic foster care homes. The New Jersey respondent indicated that the lack of community-based residential facilities has placed some strain on the generic foster care system. South Carolina noted that it has been unable to fill the demand for foster care placements and now has a waiting list. Among states for which focus on smaller, more community-based residences involved increased foster care use were North Carolina, Nevada, Indiana, and Idaho. Louisiana, New Jersey, Minnesota, and Colorado respondents all mentioned use of the Medicaid waiver for Home and Community-Based Service as a major instrument to increasing foster care as a community-based residential service for children with developmental disabilities. North Dakota mentioned that litigation regarding the quality of care in its state institutions contributed significantly to their efforts to develop community alternatives, including foster care, to

institutional care. Indiana, Nebraska, Delaware, and Louisiana specifically mentioned new programs related to development of foster care options. A Wyoming program allows reimbursement at the rate of up to $1 less than the next most restrictive environment in order to find a foster home that can provide appropriate care (e.g., if a group home would cost $900 per month, a foster home could be reimbursed at up to $899). Other specific programs mentioned include Nebraska's moves to establish more and better family-centered services for youth with severe emotional or behavioral problems and Delaware's success with a program paying higher per diem rates ($40 per day) for certain foster homes serving severely emotionally disabled children and youth.

Generally, then, around the country there appears to be a significant appreciation of the potential role of both generic and specialized foster homes for children and youth with disabilities. The development of such programs appears to be stimulated by both philosophical and financial factors. Philosophically, state respondents note a desire that children and youth be raised in natural or adoptive families, but when that is not possible that they be raised in the most typical family setting feasible. Financially, it is evident that both state and federal governments are showing greater flexibility in supporting such placements. States are establishing supplemental funding to provide adjustments to basic foster care rates to support the placement of children and youth with relatively high needs for care, supervision and training. States are making greater efforts to establish support programs, including respite care and increased case management and training for foster care homes for children and youth with handicaps. Such efforts are, of course, greatly stimulated by the relatively low costs of family foster care, as compared with the larger group settings, which are noted particularly in times of concern over total long-term care budgets. Finally, new flexibility at the federal level through the Medicaid Waiver has stimulated access to significant federal funding for foster care arrangements. Much of this change has not been seen in the "generic" foster care systems, but instead

in the expansion or development of new specialized foster care programs by the state agencies responsible for specific disability groups. Nevertheless, most foster children with handicaps are in generic programs. Specialized foster care is more likely to be used by handicapped adults. Increasingly, the benefits of foster care for dependent adults is being recognized for the same philosophical and financial reasons noted above for children's programs. Unlike children's programs, foster homes for adults are considerably less numerous and less likely to be operated by generic social service agencies.

Adult Foster Care

To better understand the extent of foster care utilization for adults, a telephone survey was carried out with representatives of adult service agencies in each of the 50 states and the District of Columbia. This survey revealed a complex and diffuse array of homes for adults, both licensed and unlicensed, supervised and unsupervised, of varying sizes and called by many different names, including family homes, county homes, licensed residential homes, shelter homes, care homes, boarding homes, and homes for the aged (among many other names). The present report examines one specific type of placement, adult family foster care.

Unlike those for children and youth in foster care, there are no federal requirements for reporting adults in family foster care. Development of intra-state statistical programs has been left to the discretion of the individual states. As will be described in this report, these data systems are not well developed, leaving relatively few statistics on which to base general observations on foster care for adults.

A major difference between adult foster care and foster care for children is that while children's foster care primarily serves nonhandicapped persons, adult foster care is totally committed to persons who are handicapped by mental, sensory, and physical handicaps. Generally, adult foster care is an alternative to other types of residential care, including board and care homes, nursing homes, or large congregate care facilities.

Many types of adult residential placement, including foster care homes, are paid for directly by clients using their social security funds (retirement, Supplemental Security Income or Disability Insurance) or private funds, with counties and states having no direct financial involvement. Therefore, in the absence of both reporting requirements and funding obligations, states often have no accurate idea about the number of adult residential placements. In states which license such facilities for adult residents, the number of licensed beds may be available, but seldom is the number of residents or the characteristics of residents.

In most states, residential service systems are organized around a recognition of three primary groups of adults requiring supervised long-term care: 1) persons who are mentally retarded or developmentally disabled; 2) persons who are mentally ill; and 3) persons who are physically and/or medically handicapped, including frail elderly people. In many states, individual offices responsible for each of these groups (i.e., agencies of mental retardation, mental health, aging) have taken the initiative in developing family foster programs for some members of their particular clientele. In these cases, the state role and responsibility for adult services is reasonably well defined within the categorical designations in which programs have developed. In such instances information can usually, although not necessarily easily, be obtained on both program participation levels and the means and amounts of funding. Even within these primarily state systems it is important to recognize the common and important generic social services department involvement. Commonly the generic local agency opens the adult "cases" as needed in order to solve an immediate problem. Such involvement often includes assistance in locating a permanent residential placement, perhaps by referral to another division such as mental retardation or aging. While this may sometimes be adequate to close a case, increasingly generic agencies indicate that a lack of available services in states systems prolongs generic agency involvements, and increasingly requires the generic agency to identify and secure

appropriate residential placements. Obviously the roles and service burdens of the generic agencies vary from state-to-state, and within state by the varying activity of categorical disability agencies in securing suitable foster care or other residential placements. A lack of mental health services is frequently mentioned as placing increasing burdens on social service agencies at the local level. Another common role of the generic agency is to establish an individual's eligibility for federal and/or state cash assistance and related benefits, and then to assist clients in establishing their own unmonitored living arrangements. Reasons given for referrals to specialized state divisions range from the need to maximize the use of other funding sources for residential care (when possible) to the need to access the specialized agencies' programmatic expertise to ensure the best quality of services.

Although adult social services respondents often made programmatic and funding distinctions between generic foster care and specialized foster care, it was also the case that program boundaries were often blurred. Because adults do not require family foster care unless they have a disability, there are often specialized disability criteria for eligibility even if the program is generic (i.e., social services operated). In some states adult foster care programs have state funding and state rules but with licensing, case management and/or provider training provided through the local social services agency. At least one state (Pennsylvania) has an adult foster care program administered by an office totally separate from both the generic and the specialized systems.

Information on the various types of adult foster care programs in 50 states and DC are presented in Table 11. According to respondents (who were usually adult services administrators or specialists in the State Department of Social Services or Public Welfare), there were generic adult family foster programs in 22 states in 1986. These are programs that generally do not restrict eligibility for family foster care to a specific disability, with eligibility typically based on income and need for assistance. Four states indicated

Table 11

Existence of Adult Foster Care Programs
Reported by State Social Services Offices

State	Generic Adult Foster Care	Specialized Adult Foster Care		
		MR/DD	MH	Aging
Alabama	X	X	X	
Alaska		X		
Arizona	C,P			
Arkansas		X	X	
California		X		
Colorado		X		X
Connecticut		X		
Delaware	X	X	X	
Dist. Columbia		X		
Florida	X			
Georgia		X	X	X
Hawaii	X			
Idaho	X	X	X	
Illinois		X	X	
Indiana				
Iowa	X			
Kansas	X		X	
Kentucky	X	X		
Louisiana		X		
Maine	X	X	X	X
Maryland	UD			
Massachusetts	X			
Michigan	X	X	X	
Minnesota	X	X		
Mississippi	P			
Missouri		X	X	
Montana	X			
Nebraska	X			
Nevada		X		
New Hampshire		X	X	
New Jersey			X	
New Mexico	N			
New York	X	X	X	
North Carolina	X	X	X	
North Dakota	C			
Ohio	C	X	X	X
Oklahoma	N			
Oregon		X	X	X
Pennsylvania	X	X		
Rhode Island		X		
South Carolina	P (state lic.)			
South Dakota	X			
Tennessee	X			
Texas	X			
Utah				X
Vermont		X		
Virginia				
Washington	X			
West Virginia				
Wisconsin	C			
Wyoming	X			

X indicates program exists
N no program exists
C certain counties have programs
P there are some privately operated programs
UD a program is under development

that adult foster care is not available statewide, but that certain such programs are operated by counties within the state.

In 25 states, respondents indicated that there are adult family foster care programs operated by the state mental retardation/developmental disabilities agency, 16 states have programs operated by the mental health agency, and six states have foster care programs operated by the agency on aging. Some caution may be warranted with these reports, since they were by staff members of the state social services agencies. Had state offices of mental retardation, mental health, and aging been surveyed, other specialized adult foster care programs might be more accurately identified. Arizona, Mississippi, and South Carolina indicated that some private agencies operate adult foster care programs within their states, with the provider agencies administering the programs, although a license may be required. Maryland indicated that although adult family foster care homes do not presently exist, plans to develop a program are being formulated.

Number of Adults in Foster Care

Table 12 presents information on the number of individuals in generic adult foster care by handicapping conditions in states able to provide such information. As this table indicates, the number of adults in foster care is small compared to the number of children in foster care. Of the 20 states able to provide data on both the number of children and the number of adults in foster care, children numbered 108,843 and the adults 30,156. The largest program in the country is Michigan's, with over 14,000 adults in a foster care program administered by the Adult Community Services Division of the Department of Social Services. In fact if Michigan were excluded from the 20 reporting states, the proportion of persons in generic foster care who were adults would be just 14.2% of the total (16,066 of 112,962). At the other extreme were three programs with less than 100 individuals (Wyoming, with 19 people, Tennessee with 20 people, and Iowa with 98 people).

Table 12

Number of Adults in Social Services Foster Homes

State	Data Date	Total Number Adults in Foster Care	Not Handicapped	Mentally Retarded	Mentally Ill	Physically Handicapped	Elderly	Other
Alabama	10/85	347						
Delaware	12/31/85	225		30	20	45	130	
Florida	7/1/85	748			385	363		
Hawaii	3/1/85	1,755 (e)		482 (e)	626 (e)	647 (e)		
Idaho	2/86	191 (e)		70	21	100 (e)		
Iowa	12/31/85	98	24	51	13	9		25
Kansas	12/31/85	157						
Kentucky	2/85	1,350						
Maine	7/10/85	31						
Massachusetts	12/85	250						
Michigan	12/31/85	14,090		3,283	3,832	1,099	5,242	634
Minnesota	5/1/86	900 (e)	120 (e)	450 (e)	200 (e)	90 (e)		160 (e)
Montana	6/6/86	216 (e)	42 (e)	147 (e)	21 (e)	6 (e)		42
Nebraska	12/85	460 (e)						
New York	12/31/85	5,887		4,381 *				
North Carolina	12/85	unk						
Pennsylvania	12/85	2,000 (e)		800 (e)*				
South Dakota	12/31/85	104				65	36	3
Tennessee	12/85	20				15		5
Texas	12/85	554		60	86	133		275
Washington	1/86	785	429	356				429
Wyoming	12/85	19	2		10	7		2

e estimated number
* includes both mentally retarded and mentally ill individuals

These programs were reported to be small either because of relatively few people needing the service or because the program was only recently developed.

Management of Adult Foster Care Programs

Only 15 of the 22 states with statewide generic adult programs keep data on type of handicapping condition even though all adults in foster care are in care because of some disability. Even among the minority of states that were able to report statistics on clients' disabilities, the data elements in the MIS programs are not fully comparable. For example, while most systems report at least three major categories of adult disability (mental retardation/developmental disability, mental illness and physical disability), some states combine categories such as mental retardation and mental illness. Three states distinguish between elderly and physically disabled while most others include "frail elderly"

persons in a physical disabilities category. Some states report a "nonhandicapped population," which probably includes elderly persons with significant limitations in functional abilities.

Table 13 summarizes the contents of the management information systems of the 22 states operating generic foster care programs for adults. Eleven states reported the existence of a statewide system of managing information about adults in foster care, three states were able to derive this information from a database maintained to track SSI recipients (to whom SSI supplements were provided), two states had alternate reporting systems, and six states, if able to report the number of adults in foster care at all, relied on periodic surveys on review of case files. The lack of data on adults in foster care (compared to data on children in foster care) no doubt relates to the limited direct state financial outlay for adult foster care (clients usually use their own SSI or private funds), the short term problem solving approach taken in making an adult foster care placement, and of course, the lack of a federal requirement to do so.

Table 13

Adult Foster Care: Management Information Systems

State	MIS or alternate data collected	Manual or Computerized	Freq. of Update	Handicap Recorded	Placement Type Recorded
Alabama	MIS	C	Monthly	No	Foster care
Delaware	SSI sys.	M	Case change	Reas. for plcmt - MR/MI/health	Foster care & others
Florida	MIS	C	Case change	Medical diag.	Foster care & others
Hawaii	MIS	C	Case change	No	11 categ.
Idaho	Region rep.	M	Quarterly	Reas. for plcmt - MI/DD/age	Foster care
Iowa	MIS	C	Monthly	9 categories	15 categ.
Kansas	MIS	M	Monthly		Foster care
Kentucky	SSI sys.	C	Quarterly		
Maine	No				
Massachusetts	No				
Michigan	MIS	C	Case change	8 cat.	AFC, home for aged
Minnesota	MIS	C	Case change	10 cat.	23+ categ.
Montana	SSI sys.	C	Monthly		
Nebraska	No				
New York	MIS	C	Quarterly		
North Carolina	County rep.	C	Yearly	as yes or no	
Pennsylvania	No				
South Dakota	MIS	C	Monthly	Aged, blind, disabled, other	Foster care
Tennessee	No				
Texas	MIS	C	Case change	as yes or no	None
Washington	MIS	C	Case change	No	Foster care
Wyoming	No				

Respondents from the states which had generic adult foster care programs were asked several different types of questions about policies and practices regarding adult foster care. These are summarized on Table 14.

Training/case management. Only 3 of the 22 states with generic foster care programs require annual training for adult foster home providers: North Carolina requires 15 hours annually, South Dakota two, and Washington twelve. Minnesota has a proposed requirement of twelve hours, and Nebraska has a proposed requirement of six hours annually.

Table 14

Adult Foster Care: Interagency Coordination

State	Required Minimum Annual # Hrs of Training	Case Management Conducted by			Same License MR/DD & Generic AFH	Interagency Agreement MR/DD & Generic AFC	Differences in Recruitmnt Selection of Foster Home-Generic & MRDD
		County	State	Priv. Agency			
Alabama	0	X			No	No	No
Delaware	0	X		X	Yes		
Florida	0		X		No	No	No
Hawaii		X			No		No
Idaho			X		Yes	No	Yes
Iowa	0*		X		Yes	No	Yes
Kansas	0	X					
Kentucky	0		X		No	No	
Maine	0		X		Yes	No	No
Massachusetts				X			
Michigan	0	X			Yes	Yes	Yes
Minnesota	0**	X			Yes	No	Yes
Montana	0	X			Yes	No	No
Nebraska	0**	X			Yes	No	No
New York		X			No	No	No
North Carolina	15	X			No	No	Yes
Pennsylvania		X	X		No	Yes	Yes
South Dakota	2		X		Yes	No	
Tennessee	0	X			No	No	No
Texas	0		X				Yes
Washington	12		X		Yes	No	No
Wisconsin	0	X			Yes	No	No
Wyoming	0	X			No	No	Yes

*Individual caseworker provides training.
**Proposed: Minnesota, 12, Nebraska, 6.

Thirteen of these 23 states have case management systems that are operated by county social services offices; in eight states case management is carried out by regional state social services agency staff; two states use private agencies to provide and monitor the service. When asked about differences in case management and/or in monitoring andevaluation between generic and specialized adult foster homes, three of the five states noting differences (Michigan, Delaware, and Wyoming) reported that more resources are available for case management and monitoring of specialized homes, that specialized homes had both more funding and more resources available to them, and that there was more involvement of case managers with clients and with day program providers on the specialized programs. Tennessee's respondents noted much the opposite: that monitoring and evaluation were more or less continuous for the generic homes, but only conducted annually or when problems arose in the specialized homes.

Interagency cooperation/agreements. Respondents from eleven states noted requirements that generic adult family homes have the same license as specialized mental retardation/developmental disabilities foster homes; eight noted requirements of some other or additional type of licensing for specialized homes and providers. When comments were volunteered on licensing, they generally indicated that licensing standards for specialized homes were more stringent.

Michigan, which has the largest number of adult foster homes in the country, was the only state that reported an interagency agreement between the state social services and mental retardation agencies regarding adult foster care. Four respondents indicated that the lack of an agreement has caused some problems. Alabama reported that a lack of coordination makes it difficult for people to obtain needed services in certain areas of the state. The respondent from Kentucky reported that problems exist in establishing social services homes given the disparity in reimbursement rates between generic (relatively low) and specialized homes. Tennessee's respondent reported occasional

problems in planning for adult services and in the recruitment of homes--problems that could be eased through interagency cooperation. Wyoming reported difficulty in determining appropriate client placement and payment responsibility given the present absence of cooperative agreements regarding adult foster care.

Recruitment/selection of providers. Respondents from eleven states reported that there were no formal differences in recruitment and selection of a home for a person who has a handicap compared to one who does not. Respondents from seven states reported differences ranging from the minor and pro forma, such as the provider's expressed willingness to accept a person with a handicap, to the more significant such as having a domicile meeting standards established for handicapped individuals, or taking part in extensive preservice training before placement.

The monthly reimbursement rates for the adult programs were reported to vary from $228 per month to $580. This compares with an average monthly rate of $690 per month for 76 specialized foster care homes in a 1985 national probability sample of foster homes. Social security payments (Retirement, Supplemental Security Income and Disability Insurance) are reported to provide the bulk of these payments, with some states supplying additional reimbursement. However, on a state-by-state basis respondents reporting this information noted that reimbursement for specialized homes is typically not much greater than the generic home reimbursements, with Michigan, Minnesota, and Wisconsin noted as exceptions.

Differential use of generic and specialized adult foster homes. When asked about the relative benefits of generic and specialized foster care, respondents noted the following as favoring generic foster care for adults: less stigma for clients (Delaware), wider availability of types and locations of homes (Michigan), more homelike settings (Minnesota), similar and less costly recruitment and licensing of homes and providers (Montana), better opportunities for case managers to work more closely and on a more

ongoing basis with providers (Tennessee), better ability to use foster care effectively in delaying or preventing other long-term care placement (Texas), more integrated community resources (Wisconsin), least restrictive for residents (Wyoming), and in most instances the lowest cost (Minnesota).

Advantages noted for specialized adult foster homes included better availability of basic support services such as respite and daytime programs (Delaware, Michigan); availability of additional funds to compensate providers (Florida, Michigan); availability of special resources (personal and funding) to meet individual needs (Hawaii); ability to make better matches between client and provider (Hawaii); availability of specialized providers' skills and special training programs for providers (Wisconsin); providing the least restrictive environment of all state programs (Minnesota); allowing better focus on individual service plan development and follow-up (Hawaii); and closer coordination of services with state planning and program agencies (Delaware). Disadvantages or disincentives that were noted for use of generic adult foster homes included that providers were inadequately reimbursed for services rendered (Alabama); that payment rates do not attract the caliber of provider needed (Florida); that reimbursement rates have not increased at the pace of the costs of care (Michigan, North Carolina); the lack of a differential reimbursement rate based on level of resident disability or level of care needed (Tennessee); inadequate training, if any, of providers (Delaware, Wisconsin); that there are few daytime activities and no respite opportunities (Delaware) and frequently inadequate case management (Wisconsin); that there are too few homes and insufficiently qualified providers (Minnesota); and that adult foster home providers often incorrectly evaluate their own capabilities in taking on clients (Washington). Finally, a number of respondents commented on the difficulty of assuring appropriateness and quality in generic foster care settings (e.g., Montana, Texas). It was noted that ideally such placements would be followed by an extensive, coordinated client assessment and evaluation system,

but that coordination is often lacking among the numerous state and local agencies with some type of case responsibility (North Carolina) and that problems with assessment and evaluation services are particularly acute in areas of sparse population (Wyoming).

Among problems noted for specialized foster care homes were the substantially more stringent service requirements (although with additional reimbursement for providers, Delaware); issues with respect to eligibility and boundary definitions between generic and specialized programs (Michigan); and the time, difficulty and lack of sufficient resources to develop programs at a pace to meet current needs (Minnesota, Wisconsin).

Trends in the use of generic adult foster care. Respondents were also asked what trends, if any, were evident or planned in their state in the use of the generic foster care for handicapped adults. A number of state respondents (Delaware, Michigan, Nebraska, and Tennessee) reported no basic changes planned in their development of foster care for adults, although this often implied a continuing expansion of programs. Other state respondents (Montana, Texas) noted that in addition to the use of foster care for adults with developmental disabilities, there has also been emphasis on placement of persons with mental illness into foster care homes. Tennessee's respondent commented that most people in their adult foster homes would continue to be elderly. Delaware's respondent noted that, although there was a cross-over into generic homes in the past, efforts continue to develop specialized homes for those persons deinstitutionalized. Minnesota and Texas respondents mentioned court cases as having created requirements for community placements and that, because of concern about the costs and appropriateness of community ICF-MR expansion in recent years, foster care was an option getting considerable attention. Minnesota, New Jersey and Wisconsin respondents specifically mentioned that their Title XIX Home and Community-Based Services waivers have increased use of adult foster homes. North Carolina's respondents mentioned that the lack of appropriate community alternatives has increased the use of generic foster

homes, and Kansas' respondent commented on the rapid growth of generic adult foster homes (from 44 in March 1983 to 157 in December 1985), mainly due to an effort to keep people at home and prevent institutionalization.

Other comments regarding trends had to do with regulatory matters. Florida, which sees a need for mandatory training requirements and a need to develop specialized homes for mental health clients, noted a trend toward greater formal state involvement in both areas. In Iowa it was noted that the lack of program development is primarily due to staff shortages which have hampered recruitment. Hawaii's Department of Health noted a five year plan to expand community-based care. Under that plan the Department of Health has become the single state agency responsible for licensing of all domiciliary care facilities, including licensing of adult foster care homes for persons with developmental disabilities. It has also been recommended to transfer case management for developmentally disabled persons in domiciliary care to the Department of Health to improve the coordination of this effort.

Specialized Foster Care

As noted throughout this report, information about generic foster care arrangements and the persons residing in them are limited by the information systems presently existing. Better data exists on specialized foster care settings, at least with respect to persons with developmental disabilities. Specialized foster care has been included in the national studies of residential services operated, licensed or contracted by states for persons with developmental disabilities. As part of its national census studies of residential services (as of June 30, 1977 and as of June 30, 1982), the Center for Residential and Community Services has gathered considerable data on specialized foster care settings, some of which are summarized here.

The primary characteristic of a foster home placement (as compared to a group home) is that an existing family brings into its home one or more dependent persons who

are not family members. Specialized foster homes differ from generic foster homes in several respects. First, specialized homes are considerably more likely to be specifically licensed, usually at the state level, to provide family care services to people with mental retardation and other developmentally disabled people. Second, most specialized foster homes serve adults rather than children (63% of the residents are 22 years or older). Third, specialized foster care providers are generally required to receive training specifically related to developmental disabilities. Fourth, while generic foster care is usually temporary (median length of stay is 1.6 years [Tatara & Pettiford, 1985]) specialized foster home placements are usually established as long-term care placements. Fifth, specialized homes usually have reimbursement rates that are higher than generic foster care, under the presumption of greater difficulty of care and/or as payment for special services. However, while its average cost of care may be higher than generic foster care, specialized foster care tends to be the least expensive type of out-of-home residential care for people with disabilities. A major reason for the relatively low cost of both forms of foster care is simply the extensive amounts of donated capital (e.g., house, furniture, appliances) and time provided by members of foster families. Despite relatively low costs, in terms of the in-home ratio of care providers to residents, specialized foster care tends to offer the highest level of supervision of all types of facilities in state residential care systems. Furthermore, specialized foster homes, like generic homes, are an excellent means of providing people who have disabilities with normal living experiences, community involvement, and contact with non-handicapped persons. In this section of this report, statistics are provided on specialized foster care as it compares with small and intermediate size group homes (6 or fewer residents and 7-15 residents, respectively), which are, along with specialized foster care, the most rapidly growing of all residential care models and the most commonly used models of "community-based" residential care outside the natural family.

Generally *group homes* consist of dwelling units that are specifically built, owned, or rented for the purpose of providing residential care and active habilitation to 15 or fewer persons. They have paid staff (live-in or shift) that provide 24-hour supervision and training. In general, group homes represent the most highly structured and professionalized model of community-based residential service in contrast not only to specialized foster care, but also to boarding homes, small personal care homes and semi-independent living arrangements.

Although there has been a rapid growth in the number of specialized foster homes and the number of group homes nationally, there also has been substantial variation among states in how and in what types of programs have been developed. Some states (e.g., New York, Nevada, Michigan, Arizona, California) have devoted considerable effort to developing specialized foster care arrangements, while Minnesota, Rhode Island and Pennsylvania have developed, until recently, primarily a group home based residential care system. In Table 15 specialized foster care and group home care are compared on a number of factors relevant to their utilization nationwide.

Total facilities and residents. Specialized foster care homes were the most numerous residential facilities for mentally retarded people nationwide in 1982 with 6,587 homes compared to 6,414 group homes. However, because specialized foster care homes have an average of fewer than 3 residents per facility as compared with nearly 7 in group homes, the total number of residents with mental retardation (17,147) was considerably less than the number of residents in group homes (43,588).

Type of operator. Specialized foster care is by its administrative nature a "private proprietary" service, even though "profits" are usually negligible and profitability is often not a primary factor in the decision to provide care. Group homes on the other hand, are predominantly operated by private, non-profit agencies (64%).

Table 15

Characteristics of Specialized Foster Care Homes and Group Homes
June 30, 1982

Characteristics	Special Foster Care	Group Homes		
		Small (2-6res)	Intermed. (7-15res)	Total (2-15res)
Homes				
Total facilities	6,587	3,557	2,857	6,414
Total residents	18,252	15,982	27,606	43,588
Total MR residents	17,147	15,701	26,317	42,018
Avg. residents per facility	2.8%	4.5%	9.7%	6.8%
Type of Operator				
Private/prop.	100.0%	28.6%	25.3%	27.1%
Non-profit	.0%	64.0%	63.2%	63.6%
Public	.0%	7.4%	11.5%	9.2%
Res. per direct care staff at 7:30 p.m. weekday	1.9	2.9	4.9	3.8
Percent opening new address between 1/78and6/82	46.7%	70.7%	47.2%	60.0%
Avg. per res. per day reimbursement rate	$16.15	$41.22	$36.60	$38.31
Residents				
Level of retardation				
Borderline/Mild	25.9%	25.1%	31.8%	29.3%
Moderate	37.7%	37.1%	38.4%	37.9%
Severe	26.0%	25.6%	21.9%	23.2%
Profound	10.4%	12.2%	7.9%	9.5%
Functional limitations				
Nonambulatory	9.3%	7.4%	4.1%	5.3%
Cannot talk	24.9%	23.0%	14.1%	17.4%
Not toilet trained	13.1%	9.4%	5.1%	6.7%
Age				
<22	37.4%	25.8%	16.4%	19.8%
22-39	32.0%	51.6%	54.4%	53.3%
40-62	23.1%	20.5%	25.7%	23.8%
63+	7.6%	2.2%	3.5%	3.0%

Residents per direct care staff member. There are two general ways that staffing ratios in different residential facilities can be compared. One way is to compute the ratio of all staff full-time equivalent (FTEs) or direct care staff FTEs to residents (i.e., compute an "average" daily staff to resident ratio). A second way is to pick a particular time of day and to compute the ratio from total or direct care staff and total residents actually in the facility at that time. The second method has the advantage of allowing more meaningful comparison across facilities whose staffing arrangements may include nontraditional staffing, as with foster parents, live-in staff, or split-shift staffing.

Table 15 shows the average resident to staff ratios computed from the reported number of direct care staff (adult household members in the case of foster homes) and the number of residents actually at home in facilities at 7:30 p.m. on a typical weekday. As can be seen, the resident-to-direct-care staff ratio in specialized foster care is favorable to that of group homes. Even if one were to assume that only half the adults in these homes were actually performing a direct care function, specialized foster care appears to represent a considerable bargain in the purchase of direct care service given the relatively low cost of the placements. Although this comparison focuses on small facilities, it is notable that both types (foster homes and group homes) compared very favorably to large private facilities (7.7 residents per direct care staff member) and large public facilities (7.1 residents per direct care staff member).

Percentage of new facilities. Table 15 also shows the percentage of community-based facilities of the different types operating on June 30,1982 that opened in 1978 or later. Specialized foster care settings showed a relatively high rate of new facilities, although the number of residents increased only from 14,000 to 17,000. Some of those new facilities were new foster facilities; others were "new" to their address (50% of all American families move in 5 years). Some foster parents stopped providing care (closed); in group homes staff turnover is common, but staff who leave are generally replaced

without affecting the survival of the facility itself. Altogether, the 60% rate of "new openings" among group homes from January 1978 through June 1982 was considerably higher than the rate for foster homes, and much higher than the 16% increase in public and private facilities of 15-299 residents and 1% for facilities of more than 300 residents over the same period.

Cost of care. Foster care and group home models tended to show considerable variation in cost of care, ranging from specialized foster care with average daily reimbursement rates in 1982 of $16.15, to group homes with an average daily cost of about $38. Both community models compared quite favorably with large group facilities, which average $45 and $85 a day for large private and public facilities respectively.

Level of retardation. Most of the population (60.5%) of public and private residential facilities for persons with developmental disabilities in 1982 had severe or profound mental retardation; 36.4% of the persons in specialized foster care, 37.8% of the persons in group homes of 6 or fewer residents, and 29.8% of those in group homes of 7-15 residents were severely/profoundly retarded. The presence of over 6,000 persons with severe or profound mental retardation in specialized foster care settings demonstrates the viability of this option as a placement option for many people in more restrictive settings.

Functional limitations. Generally, specialized foster care providers reported relatively high percentages of their residents to have significant limitations in areas which would tend to increase the "burden" of care. For example, 9.3% of specialized foster care residents were reported to be nonambulatory as compared with 5.3% of group home residents; 13.1% were reported not to be toilet trained in comparison to 6.7% of group residents. While level of mental impairment of residents is probably not in itself a major factor in this difference (see Table 15), the interaction between the slightly more severe impairments of the foster care populations and their substantially younger ages is probably a significant factor in the developmental differences between the populations in functional

areas. Specifically while 9.3% of specialized foster care residents were 9 years or younger, only 1.8% of group residents were in that age group.

Age. The vast majority of residents in state residential care systems in general and in specialized foster in particular are adults. In 1982 two of the most popular models of care for children (persons 21 or younger) were foster homes and group homes serving 6 or fewer residents, but even their populations were 63% and 74% adults (22 years or older), respectively. Overall, between 1977 and 1982 there was a modest increase in the number of children and youth in specialized foster care and group homes (from about 13,000 to 15,000). Placement of children and youth in specialized foster care increased from about 5,700 to 6,400 during this same period. On the other hand, the number of children and youth (21 and younger) in the largest institutions (those with more than 300 residents) decreased by 1982 to less than 50% of the 1977 total (from 49,800 to 23,350). Overall, the total number of children and youth in all types of residential facilities for mentally retarded people decreased between 1977 and 1982, from about 91,000 to about 60,000. Over one-half of this decrease was accounted for by the decrease of about 16,000 in the number of children under 10 (to about 22,200). As shown by the statistics gathered in this study, these trends were in no way promoted by any shifting of populations of children with mental retardation to generic foster care. Indeed, this study has shown that over a nearly concurrent time period there was a very similar trend in both direction and magnitude toward decreasing placements of children with mental retardation in generic foster care.

State-County Population Estimate

The methodology section of this paper described a procedure by which three counties of small, intermediate and large sizes were selected in each of ten geographically representative states. The purpose was to gather information to permit an assessment of the differential availability of foster care statistics at the state and county levels,

particularly with respect to persons with handicaps, and to examine the potential and recommended methods of sampling counties as a means of gathering statistics on children and adults with handicaps in generic foster care settings. Table 16 provides a summary of findings from the states and counties surveyed.

The county survey demonstrated that counties are able to supply information on the number of children and youth in foster care settings with handicaps in general and with mental retardation specifically. Of the thirty counties surveyed regarding the total number of children and youth in foster care and the number with handicaps, 25 responded. Of these all 25 were able to report the number of children and youth in foster care and 23 of the 25 were able to report the number of children in foster care with any form of handicap and with mental retardation specifically. As noted earlier and as shown in Table 6 (as indicated by an "e", for estimated), only 35 states were able to report the number of children with handicaps in generic foster care and only 33 could report the number of children specifically with mental retardation. Clearly, then in terms of data availability, counties are more often able to report statistics on the number of children and youth with handicaps in generic foster care.

The major problem in obtaining statistics from counties is the large number of jurisdictions involved, nearly 2,500 nationwide. As noted above this study suggests that counties can provide basic population statistics, but it is less clear how accurate these numbers are how and large an adequate sample would be. In the present feasibility study, one small, one intermediate, and one large county was selected in each sample state, and the relative proportion of the state population in large, medium, and small counties was calculated (referred to in Table 16 as its "Weight"). Based on the reported statistics multiplied by the weight of each sampled county, a statewide estimation of the population of handicapped children, of mentally retarded children, and of total children in generic foster care was computed.

Table 16

Foster Children and Adults Reported by Selected Counties: 1980 & 1985

State/county	1980 Population	Pop. Represented	Wt.	CRCS - 1985 MR	CRCS - 1985 Hand.	CRCS - 1985 All	OCR - 1980 MR	OCR - 1980 Hand.	OCR - 1980 All	Adults - 1985 MR	Adults - 1985 Total
AZ											
Gila	39,312	337,896	8.6	0	1	1				0	0
Coconino	74,841	74,841	1.0	8	20	53				0	0
Pima	526,596	2,305,478	4.4	68	81	596				42	564
Statewide est.				306	383	2,671					
State reported	2,718,215	2,718,215		54	1,092	2,626	224	1,173	2,170		
CA											
Lassen	22,405	714,555	31.9	1	1	40	0	0	10	0	0
Tulare	241,129	9,261,965	38.4	15	70	600	6	27	248	0	0
Orange	1,942,248	13,691,382	7.0	42	832	2,045	43	1,072	1,072	0	0
Statewide est.				904	8,586	38,738					
State reported	23,667,902	23,667,902		1,280 e	5,365	43,655	1,718	9,776	24,402		
CO											
Grand	7,485	499,539	66.7	1	5	12	1	2	10	0	0
Fremont	28,717	689,307	24.0	0	3	45	0	14	53	20	55
Arapahoe	365,195	1,701,118	4.7				15	27	222		
Statewide est.											
State reported	2,889,964	2,889,964		625	1,236 e	3,650	359	1,426	4,033		
GA											
Macon	13,012	2,636,288	202.6	2	2	7	0	2	10	0	0
Dougherty	102,676	1,027,609	10.0	6	8	81	16	22	89	0	0
Dekalb	479,087	1,799,208	3.8				14	51	251		
Statewide est.											
State reported	5,463,105	5,463,105		254	998	5,351	494	1,124	4,530		
MI											
Roscommon	17,651	1,930,335	109.4				0	3	31		
Jackson	151,579	2,360,642	15.6	2	52	365	4	34	106	87	309
Genessee	458,854	4,971,101	10.8	15	144	337	18	81	297	234	502
Statewide est.											
State reported	9,262,078	9,262,078		138	1,479	10,074	402	1,787	9,904		
MO											
Morgan	13,698	1,881,076	137.3	1	5	12	0	3	11	0	0
Cape Girdeau	57,616	637,887	11.1	2	35	69	2	7	51	0	0
Jackson	630,743	2,397,723	3.8				42	265	1,369		
Statewide est.											
State reported	4,916,686	4,916,686		787	2,441	6,562	374	1,335	6,191		
NY											
Chenango	49,595	1,238,095	25.0	2	19	57			100	4	10
Rensselaer	154,009	8,164,030	53.0	6	20	119			207	2	22
Nassau	1,323,935	8,155,947	6.2	22	357	717			1,082		
Statewide est.				504	3,734	12,148					
State reported	17,558,072	17,558,072		1,898 e	6,959	26,929	2,548	7,570	37,596		
PA											
Wayne	38,893	1,166,451	30.0	1	34	43	6	23	37	0	0
Fayette	168,847	5,863,458	34.7			70	14	19	113		
Allegheny	1,443,878	4,833,986	3.3	74	487	1,396			1,536		
Statewide est.											
State reported	11,863,895	11,863,895		545 e	1,392 e	13,208	731	1,606	14,435		
TX											
Kendall	12,622	3,650,422	289.2				0	0	1		
Denton	129,112	4,243,309	32.9			33	3	12	32	0	0
Dallas	1,579,753	6,335,460	4.0	23	185	679	72	206	470	3	54
Statewide est.											
State reported	14,229,191	14,229,191		368 e	1,289 e	4,692	494	1,487	5,362		
VA											
Patrick	17,496	2,509,931	143.5	0	0	8	3	10	15	0	0
Hampton City	125,091	1,315,608	10.5	14	37	112	8	40	133	0	0
Richmond City	264,718	1,521,279	5.7	89	387	842	185	633	1,113	0	0
Statewide est.				659	2,613	7,164					
State reported	5,346,818	5,346,818		422	1,045	5,309	906	2,779	8,089		

Note. Does not include placements with parents/unpaid relatives.

In only four of the 10 states (Arizona, California, New York and Virginia), were complete reports obtained from all these sampled counties on children and youth with handicaps. Therefore evaluation of the sampling strategy employed was considerably limited. Generally, it appears that the estimation procedure was unsuccessful in New York State. The "estimated statewide" number of foster children from the three counties was significantly smaller than the reported statewide population of all three groups of children and youth, mentally retarded, handicapped and total. One reason for the inaccuracy was undoubtedly that the small sample size relative to large variation among counties in New York. In Arizona the estimation procedure yielded major differences between estimated and reported populations of mentally retarded and handicapped children and youth, but very similar statistics on total children and youth in generic foster care. California and Arizona's estimated and reported populations had major differences in the total handicapped statistics and substantial differences in mentally retarded children and youth. Table 16 also reports 1980 OCR data for counties listed in the 1980 OCR report. With some exceptions, data reported to OCR five years earlier are similar to 1985 data. Because of changes that have taken place since 1980, it is impossible to judge the accuracy of county reports in either year. The data suggest, however, that the inaccuracy of estimation resulted more from the small sample of counties employed than from inconsistent data supplied by counties. Surveying counties would be a large task both because of their number and because of difficulty in getting counties to adhere to uniform definitions not imposed on them by their respective states.

One of the issues in consideration of sampling strategies is whether it is most important to maximize the proportion of the total state population represented by the sampled counties, or whether representation of different size counties is more important. One type of information bearing on this question is the foster care placement rates of different size counties in this sample. These are shown on Table 17.

Table 17 shows the foster care placement rates for all children, for mentally retarded children, and for handicapped children in small, medium and large counties. Placement rates do not show extreme variations by size, although there were somewhat higher rates of placement among intermediate size counties.

There are obviously errors that will be associated with sampling counties to estimate the number of children and youth with handicaps in generic foster care. However, at the present time if such statistics are needed, there is little alternative but to employ such sampling. The question is whether they should be used to supplement reports of states already aggregating data or whether national sampling should be used. Results from efforts to draw national samples of counties to estimate foster care utilization have shown wide variations (see Table 5 in this report). On the other hand, state statistics, as has been noted, often suffer from ambiguous or varying definitions. It seems likely, therefore, that an efficient strategy for future gathering of basic statistics on children and youth in generic foster care would be to gather statistics on total children directly from the states and to gather statistics on those children with handicaps from those states maintaining adequate statistical counts. Among those states with no existing reporting systems, it would be advisable to directly approach individual counties, sampling larger counties with certainty and smaller counties with lower sampling ratios.

Table 17

Foster Child Placement Rates by Size of County

County Size	Counties Sampled	Avg. Pop. of County	MR per 100,000	Hand. per 100,000	Total per 100,000
Small	8	25,237	4.0	33.2	89.2
Intermediate	8	116,957	5.6	26.2	125.4
Large	7	1,077,140	4.4	32.8	87.7
Average			4.7	30.7	100.8

IV. Discussion and Recommendations

As noted throughout this report, comparisons across various states' foster information systems pose numerous challenges, both with respect to standardization of data elements and to operational definition of those elements. For the purpose of this report, lack of consistency in reporting and uniformity in defining presence/type of handicap and place of residence represent two major limitations to state reporting systems as means of informing public policy. Such limitations affect the quality of data available to describe the contemporary states of generic foster care services nationwide, and the validity of many interstate comparisons of total children in foster care, children with handicaps in foster care, and type of foster placement. Related limitations in state data bases, as they are aggregated to national statistics, and among special national surveys which have suffered some of the same general definitional problems as the state data bases, have also made it difficult to assess longitudinal trends in generic foster care utilization.

While mandated state reporting systems on children in foster care in PL 96-272, the Adoption Assistance and Child Welfare Act, greatly improved access to foster care statistics, it is apparent that obtaining accurate and reliable reports on the number of handicapped children remains a problem. To improve access to such statistics would require considerably better standardization of definitions of handicaps. It would also require a standardized set of placement types and accompanying definitions and improved means of ensuring nonduplication between social services and disability agency programs. Finally, it would require means of access to data. Even in states in which good usable data are collected, special computer analyses must usually be run in order to obtain data in standard categories. States have had little incentive to gather or report precise statistics on handicapped children (or adults) in generic foster care because there has been no opportunity for comparison either to historical data or to other states. In the present study, several states that had initially stated that it would not be possible to

provide data by type of handicap, by type of placement, or according to suggested definitions, were willing to do special computer runs after seeing comparable data from other states (all states were asked to review drafts of selected tables of this report). If periodic state-by-state data were *published*, states might have added incentive, when making future changes in data collection forms, to adopt more standard definitions.[1]

Two areas of particular importance to data gathering regarding persons with handicaps in generic foster care are types of handicaps and types of placement. With respect to reporting handicaps, an essential reporting system characteristic would be simply that the presence of a handicap be coded. In a number of states no data on handicaps are gathered; in other states the presence of handicaps can only be inferred from categories such as "special needs" or "learning difficulties." There is also a need for standardized categories and definitions. At present, handicaps coded range from a majority of states gathering statistics on mental retardation/developmental disabilities, emotional disturbance/behavior disorders and physical/health impairments, to a substantial minority of states that report the number of individuals with vision and hearing impairments, neurological or learning disabilities, speech impairments, chemical dependency/abuse or "multiple handicaps" (a term with little meaning). Finally, an important case can be made for improving statistics on the degree of impairment of persons in the different categories, or at least the number of persons with disabilities of such severity as to suggest probable long-term care or other special services needs in adulthood. This might include within the mental retardation category, moderate, severe

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[1]A review of the reference list of the present report shows that with the exception of MacEachron & Krauss (1983), each of the foremost national child welfare surveys done in the last 25 years have been project reports or little known government publications with limited circulation, and not abstracted with other research literature. Without wide dissemination of state-by-state data, states have little incentive to develop standard definitions and consistent practices. It was necessary for the present authors to "get permission" to purchase certain reports, if they could be located at all. The OCR data tables, for example, were obtained from a past OCR employee who was willing to loan us a copy (2 volumes, 820 pages) that he had at home.

and profound retardation, and regarding sensory impairments, legal and functional blindness and deafness. While this latter modification would require substantially increased reporting demands, its benefits to planning efforts would also be considerable.

Another area in which increased standardization of reporting procedures would greatly improve the quality and utility of statistics reported is in the type of placement. The standardization of types of placement would require consideration of two general types of placement presently used. The first of these is the traditional substitute care -- family foster homes, group homes, and child caring institutions. The second "type" of placement noted in existing reporting is a diverse collection of other types of living situations. These include some children living with their natural parents, children living with relatives, runaways, children in hospitals and nursing homes, those in independent living situations, in maternity homes, in correctional facilities, and a number of others. There is no consistent use of these different types and usually no way to adequately combine data across categories. An effort to improve the utility of statistics aggregated from state reports must consider ways to ensure that states report comparable categories of placement.

Of course, beyond the basic data set, there are many questions about the use of generic foster care for children with handicaps that are important but that cannot be responded to with aggregated state statistics. For instance, what is the relationship between handicapping conditions and abuse or neglect of a child? What differences exist in permanency planning for children with handicaps in generic foster care as compared to specialized foster care? The answers to many of these questions would require individual children (not necessarily case records, but perhaps interviews) as the unit of analysis.

It is difficult to assess the utilization of generic foster care as a long-term care placement for children and youth with handicaps. Although these data indicate that approximately 30% of generic foster children have handicaps, only 2.6% of the cases

indicating "reason for placement" note the child's handicap. On the other hand, it is clear that handicap per se is seldom the sole reason for placement. Placement of children and youth out of home is very rare, even when they are handicapped. If one uses educational statistics (which label about 10% of children and youth as handicapped) then only about 3% of handicapped children and youth are in any form of government sponsored extra familial care, and only about 1% are in generic foster care.

If the foster care population were an average socio-demographic group, one would expect approximately 10% of children to be "handicapped," but this study indicated that about 20% were handicapped. Obviously the foster care population is not average socio-demographically. The majority of handicapped children and youth can be expected to be relatively mildly handicapped, handicaps perhaps associated with certain economic or familial conditions (e.g., mild mental retardation, behavior disorders, learning disabilities). The specific nature and severity of disabilities among the children and youth in foster care indicated to be handicapped and the impact of these handicaps in the family would be an interesting topic for future research. Such research could examine the extent to which handicaps themselves contribute to placement, or whether factors such as abuse or parent neglect may be independent factors in placement. Such research could look at the general levels of handicaps reported for children in generic foster care and the origin of the diagnosis. It could examine whether the statistics in state reporting systems reflect an official status (e.g., a diagnosis or enrollment in a school special education program) or whether it reflects a general observation by case workers (e.g., academic problems equated to learning disabilities, behavior problems equated with emotional disturbance). In short, it could provide perspective on the high prevalence (over 20%) of handicaps among foster children.

A number of respondents to this survey suggested the need for better integration or more coordination between the MR residential care system and the local social services

systems. They particularly noted the benefits that could be derived from greater focus on services such as prevention, in-home-support, short-term or temporary stays, and long-term planning for stable family relationships. Although the number of children in mental retardation facilities dramatically decreased between 1977 and 1982, those in out-of-home placements (including generic foster care) are still considerably more likely to be in group residential settings rather than in family care (approximately 70% to 30%). This reality, in a time when normalized patterns and conditions of daily living are strongly supported in program, research and policy, seems unacceptable. When compounded by the significantly lower costs of foster care, current placement patterns seem all the less congruent with stated principles.

Adult foster care as a "nonspecialized" social service is relatively new in many states; several states are in the process of developing such programs. Unfortunately data regarding generic adult foster care programs are extremely limited. To gather useful information on the individuals in such care would require major changes in the way almost all states gather individual client-level information from local agencies. In most states, information is not kept at all, and knowledge of adult generic foster care programs is limited to the licensing of beds and the results of annual inspections of care.

Data presently available from states on total children, handicapped children, and mentally retarded children in generic foster care appears reliable, but incomplete and not adequately comparable across states. Given that most states already invest considerable effort on gathering and coding substantial amounts of information on children and youth in foster care, it seems unfortunate that a basic suggested set of data elements (such as some of those in the APWA - VCIS system) has not been more strongly promoted among states. In that modest changes in data collection efforts could produce a rich data set useful to the states, it would seem advisable for ASPE to pursue improving the quality and coverage of data presently reported.

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Appendices

Appendix A

Definitions

Foster child - any child in public foster care, or in private foster care but under the case management and planning responsibility of the primary state child welfare agency, who is 0-17 years old, or 18, 19, or 20 years old and entered foster care before age 18.

Foster care - any of the following out-of-home placements under the jurisdiction of the primary state child welfare agency and regarded as 24-hour substitute care, not including finalized adaptive home placements, placement with relatives who are not licensed or reimbursed, or placement made by state agencies other than the primary child welfare agency.

Family foster home: Non-secure, 24-hour, residential care in a permanent or temporary family setting (include adoptive placements that have not yet been finalized, and relatives only if they are licensed or reimbursed).

Group home (shelter, half-way house): Non-secure, 24-hour residential care facility serving up to twenty persons which provides nonspecialized physical care and may or may not offer an educational program on site.

Group home 21 + (residential treatment facility or child care institution): Non-secure, 24-hour, residential care facility serving twenty-one or more persons which provides nonspecialized physical care and may or may not offer a therapeutic service or an educational program for emotionally disturbed or otherwise handicapped youth.

Emergency shelter: Facilities used solely for out-of-home placement on a short-term basis during periods of sudden emergency, pending formulation of long-term solutions.

Secure facility (training school, reformatory, detention center, jail, secure hospital): Twenty-four hour residential care facility of any size, designed and operated to ensure that all entrances and exits are under the exclusive control of the staff, whether or not the person being detained has freedom of movement within the facility perimeters.

Independent living: A facility (house, apartment, etc.) in which a child/youth is permitted to live or reside "independently" without a paid caretaker.

Parents or relatives (own home): Return of the child to parental or non-licensed/reimbursed relative's home, with ongoing assistance and/or supervision provided.

Other or NC: Types of foster placements not listed above, or all placements for which placement type is not categorized or is not known.

Handicapped: Those individuals diagnosed as having a handicapping condition in accordance with the following definitions. Persons should not be counted as handicapped unless they have been *clinically* diagnosed as having these conditions. Use one primary diagnosis for multiply handicapped children.

Mentally retarded: Significantly subaverage general intellectual functioning (specifically an I.Q. below 70) existing concurrently with deficits in adaptive behavior manifested during the developmental period (age 0-21).

Seriously emotionally disturbed: A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects daily activities: an inability to learn which cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers or teachers. Inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness of depression or a tendency to develop physical symptoms of fears associated with personal or school problems. The term includes persons who are schizophrenic or autistic. The term does not include persons who are socially maladjusted, unless it is determined that they are also seriously emotionally disturbed.

Specific learning disability: A disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculation. The term includes such conditions as perceptual handicaps, brain injury, and minimal brain dysfunction.

Hearing, speech, or sight impaired: A hearing impairment, whether permanent or fluctuating, which adversely affects a child's/youth's educational performance; a communication disorder, such as stuttering, impaired articulation, a language impairment, or voice impairment, which adversely affects educational performance; a visual impairment which, even with correction, adversely affects educational performance; or, concomitant hearing and visual impairments which adversely affect educational performance.

Physical or health handicapped: One or more of the following handicapping conditions: Orthopedically impaired; limited strength, vitality, or alertness due to chronic or acute health problems such as heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, or diabetes, which adversely affects educational performance.

Other handicaps or NC: Other diagnosed handicaps, multiple handicaps when it is not possible to ascertain one primary diagnosis, or handicap of type not categorized.

Appendix B

Tables B-1 to B-6: Type of Handicap by Type of Foster Placement

Table B-1

Mentally Retarded Children in Foster Care by Type of Placement

State	Fos. Home	Group Home	Group 21+	Emrg. Shlt.	Sec. Fac.	Ind. Liv.	Parents or rel.	Other or NC	Total
Alabama	230	3	57	0		2	42	47	381
Alaska									
Arizona	45	6	3						54
Arkansas									
California									
Colorado	385	95	135	10		18			643
Connecticut	23	2	15	0	0	0		0	40
Delaware									
Dist. Columbia									
Florida	2	2	22	2		0	2	31	61
Georgia	254								254
Hawaii	50	4	0	0			4		58
Idaho									
Illinois	134	6	76		3	7	130	12	368
Indiana	219	23	63	7	1	0	40	42	395
Iowa	114		328	6	4	1		10	463
Kansas	72	29	53	2		0	31	16	203
Kentucky									
Louisiana	234	56					77		367
Maine									
Maryland	91		55	5	0		9		160
Massachusetts									
Michigan	94	2	36	4	1	8	45	1	191
Minnesota									
Mississippi									
Missouri	460	39	243	3	5	9		37	796
Montana									
Nebraska	55	27	17	0	0	3	22	7	131
Nevada									
New Hampshire									
New Jersey									
New Mexico									
New York									
North Carolina	91	4	26	0	0	2	18	2	143
North Dakota									
Ohio	358		199				308		865
Oklahoma	64	0	76	0	0	0	0	0	140
Oregon	215	2	42	2	8	0			269
Pennsylvania									
Rhode Island									
South Carolina									
South Dakota									
Tennessee	244								244
Texas									
Utah	84	3	5				8	33	133
Vermont	51								51
Virginia	255		150			8	5	17	435
Washington	301	173							474
West Virginia									
Wisconsin	166	11	40						217
Wyoming									
Reported	4,291	487	1,641	41	22	58	741	255	7,536

Table B-2

Emotionally Disturbed/Mentally Ill Foster Children by Type of Placement

State	Fos. Home	Group Home	Group 21+	Emrg. Shlt.	Sec. Fac.	Ind. Liv.	Parents or rel.	Other or NC	Total
Alabama	16	2	31	1			8	1	59
Alaska									
Arizona	728	92	36			?			856
Arkansas									
California									
Colorado									
Connecticut	105	22	282	15	133	20		51	628
Delaware									
Dist. Columbia									
Florida	11	1	53	4		1	19	51	140
Georgia	289								289
Hawaii	10	0	10	1			0		21
Idaho									
Illinois	95	28	78		17	50	115	14	397
Indiana	454	87	229	31	14	2	122	41	980
Iowa	94		178	14	0	0		21	307
Kansas	31	69	55	7		2	36	13	213
Kentucky									
Louisiana	142	34					47		223
Maine									
Maryland	391		322	59	2	5	97	2	878
Massachusetts									
Michigan	364	3	375	14	31	53	200	17	1,057
Minnesota									
Mississippi									
Missouri	426	43	151	1	2	11		78	712
Montana									
Nebraska	96	40	47	5	1	3	52	14	258
Nevada									
New Hampshire									
New Jersey									
New Mexico									
New York									
North Carolina									
North Dakota									
Ohio	578		321				497		1,396
Oklahoma	56	1	10	0	19	0	0	0	86
Oregon	370	14	123	32	74	2			615
Pennsylvania									
Rhode Island									
South Carolina									
South Dakota									
Tennessee	316								316
Texas									
Utah	24	6	17		1		6	11	65
Vermont									
Virginia									
Washington									
West Virginia									
Wisconsin	46	8	33						87
Wyoming									
Reported	4,642	450	2,351	184	294	149	1,199	314	9,583

Table B-3

Specific Learning Disabled Foster Children by Type of Placement

State	Fos. Home	Group Home	Group 21+	Emrg. Shlt.	Sec. Fac.	Ind. Liv.	Parents or rel.	Other or NC	Total
Alabama									
Alaska									
Arizona									
Arkansas									
California									
Colorado									
Connecticut									
Delaware									
Dist. Columbia									
Florida									
Georgia	71								71
Hawaii	10	0	5	0			10		25
Idaho									
Illinois	22	3	9			3	32		69
Indiana	83	14	30	6	2	1	20	6	162
Iowa	24		12	3		0		3	42
Kansas	79	32	61	8		1	47	15	243
Kentucky									
Louisiana	59	14					19		92
Maine									
Maryland	313		86	13	4	1	54		471
Massachusetts									
Michigan	66	1	64	3	9	12	52	3	210
Minnesota									
Mississippi									
Missouri	449	32	197	1	1	13		82	775
Montana									
Nebraska	101	25	10	10	0	1	45	5	197
Nevada									
New Hampshire									
New Jersey									
New Mexico									
New York									
North Carolina									
North Dakota									
Ohio	785		437				675		1,897
Oklahoma	24	1	0	0	0	0	0	0	25
Oregon	23	0	8	1	3	0			35
Pennsylvania									
Rhode Island									
South Carolina									
South Dakota									
Tennessee									
Texas									
Utah	38	8	2			3	6	15	72
Vermont									
Virginia									
Washington									
West Virginia									
Wisconsin									
Wyoming									
Reported	2,147	130	921	45	19	35	960	129	4,386

Table B-4

Hearing, Sight, or Speech Impaired Foster Children by Type of Placement

State	Fos. Home	Group Home	Group 21+	Emrg. Shlt.	Sec. Fac.	Ind. Liv.	Parents or rel.	Other or NC	Total
Alabama									
Alaska									
Arizona									
Arkansas									
California									
Colorado									
Connecticut	8	0	8	0	0	1		2	19
Delaware									
Dist. Columbia									
Florida	4	1	4	0		0	2	18	29
Georgia									
Hawaii	0	0	0	0			2		2
Idaho									
Illinois	18	1	6			3	38	2	68
Indiana	123	10	31	4	0	0	24	11	203
Iowa	68		94	2	4	0		3	171
Kansas	N/A								
Kentucky									
Louisiana	27	6					9		42
Maine									
Maryland	13		7	1	0	2	4		27
Massachusetts									
Michigan	44	1	6	0	1	4	14	0	70
Minnesota									
Mississippi									
Missouri									
Montana									
Nebraska	14	4	0	0	0	1	4	1	24
Nevada									
New Hampshire									
New Jersey									
New Mexico									
New York									
North Carolina	12	0	9	1	7	2	13	2	46
North Dakota									
Ohio									
Oklahoma	33	0	2	0	0	0	0	0	35
Oregon	33	0	5	1	2	0			41
Pennsylvania									
Rhode Island									
South Carolina									
South Dakota									
Tennessee									
Texas									
Utah	7		1				1	1	10
Vermont									
Virginia									
Washington									
West Virginia									
Wisconsin	6		2						8
Wyoming									
Reported	410	23	175	9	14	13	111	40	795

Table B-5

Foster Children with Physical or Health Handicaps by Type of Placement

State	Fos. Home	Group Home	Group 21+	Emrg. Shlt.	Sec. Fac.	Ind. Liv.	Parents or rel.	Other or NC	Total
Alabama	70	0	4	1			15	13	103
Alaska									
Arizona	136	17	7			0			160
Arkansas									
California									
Colorado									
Connecticut	30	2	14	0	0	4		7	57
Delaware									
Dist. Columbia									
Florida	0	0	6	0		0	2	10	18
Georgia	141								141
Hawaii	5	0	0	1			5		11
Idaho									
Illinois	38	2	10		0	2	111	0	163
Indiana	211	13	57	6	2	1	30	45	365
Iowa	27		62	1	0	0		0	90
Kansas	85	21	13	2		0	35	9	165
Kentucky									
Louisiana	84	20						28	132
Maine									
Maryland	58		26	6	2	1	8		101
Massachusetts									
Michigan	101	0	8	1	0	7	32	0	149
Minnesota									
Mississippi									
Missouri	167	8	6	2	1	2		7	193
Montana									
Nebraska	69	13	6	2	0	3	20	3	116
Nevada									
New Hampshire									
New Jersey									
New Mexico									
New York									
North Carolina	39	3	14	1	1	0	5	4	67
North Dakota									
Ohio									
Oklahoma	30	0	25	0	0	0	0	0	55
Oregon	34	0	0	1	0	0			35
Pennsylvania									
Rhode Island									
South Carolina									
South Dakota									
Tennessee	137								137
Texas									
Utah	24	7	6			5	7	14	63
Vermont									
Virginia									
Washington									
West Virginia									
Wisconsin	34	1	4						39
Wyoming									
Reported	1,520	107	268	24	6	25	270	140	2,360

Table B-6

Other/Multiple/Special Need/Uncategorized Handicap by Type of Foster Placement

State	Fos. Home	Group Home	Group 21+	Emrg. Shlt.	Sec. Fac.	Ind. Liv.	Parents or rel.	Other or NC	Total
Alabama									
Alaska									
Arizona	19	2	1			0			22
Arkansas									
California	3,356	1,260	625			0		124	5,365
Colorado									
Connecticut	70	3	72	4	0	1		18	168
Delaware									
Dist. Columbia									
Florida	0	0	0	0		0	1	0	1
Georgia	243								243
Hawaii		0	0	0			2		2
Idaho									
Illinois	153	9	150		0	7	236	3	558
Indiana	28	3	7	0	0	0	6	0	44
Iowa	20		64	4	0	0		0	88
Kansas	216	156	36	33		3	135	59	638
Kentucky									
Louisiana	15	4						5	24
Maine									
Maryland	90		9	5	0	0	9		113
Massachusetts									
Michigan	167	0	54	4	1	4	21	3	254
Minnesota									
Mississippi									
Missouri									
Montana									
Nebraska	502	76	121	16	2	14	258	45	1,034
Nevada									
New Hampshire									
New Jersey									
New Mexico									
New York	3,840	1,125	1,991					3	6,959
North Carolina	27	1	11	0	3	0	6	6	54
North Dakota									
Ohio	373		209					321	903
Oklahoma	60	0	3	0	0	1	0	1	65
Oregon	61	0	2	2	2	0			67
Pennsylvania									
Rhode Island									
South Carolina									
South Dakota									
Tennessee	223								223
Texas									
Utah									
Vermont									
Virginia	460		143	5		20	37	15	680
Washington									
West Virginia									
Wisconsin	6		9						15
Wyoming									
Reported	9,929	2,639	3,507	73	8	50	711	603	17,520

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